



IAPPEALS REVITALIZATION 2013

SCREEN PACKAGE VERSION 2.2



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1. Screen Package Version Information

The first release of this Screen Package as a project deliverable is numbered 1.0. The second release is 2.0.

Version Number	Date	Content Revisions	Page #	Revised by
0.1 (Draft)	09/24/2013			
1.0	10/28/2013	UXG final recommendations based on research, testing	Multiple	
2.0	02/06/2014	Updated language based on Sponsor Language Change Requests (LCRs)	Multiple	
2.1	02/07/2014	Removed the Attachment Utility screens, and made appropriate modifications to pages affected by the removal of attachment utility screens	Multiple	
2.2	02/11/2014	Addressed any omissions due to multiple screens or dynamic panel edits	Multiple	

2. About this Screen Package

This screen package is intended to provide snapshots of the various possible states of the iAppeals screens.

There are some global changes for the prototype which are not reflected in this document.

1. There has been a change to the instructional text for dates. The UXG recommendation:
 “Enter the closest date [you] can remember. Examples: 6/2/2013; June 2013; Summer 2013.”

will be changed in production to:

“If the exact date is unknown, enter an approximate date. Examples: 6/2/2013; June 2013; Summer 2013.”

2. There has been a change to the field label and instructional text for side effects (for medicines). The UXG recommendation:

Describe any side effects Sarah Jones experienced while taking this medicine:

will be changed in production to:

Describe any side effects Sarah Jones has while taking this medicine:

If none, enter "None"

There are some additional minor inconsistencies (typographical errors) in the prototype that are incidental and immaterial to the OMB approval process. The work effort of correcting the inconsistencies within the prototype is prohibitively great, but these errors will be corrected in the production version of the application.

3. Third Party Screen Designs

3.1. Welcome Page

Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Getting Ready

Before you start your appeal, you should gather the [information you need](#) to complete your disability appeal, including:

- Doctors, hospitals, medical treatments, and tests since you last gave us medical information
- Medicines you are currently taking
- Changes in your medical conditions, daily activities, work, and education
- [Supporting documents](#) including forms, medical reports, and written statements

Being prepared will help you spend less time to complete your disability appeal online.

Submit an Appeal

Completing your appeal online may take 40 to 60 minutes. Your answers will be saved automatically so you can take a break at any time.

or

More Information

- [? About this Application](#)
- [? Other Ways to Complete a Disability Appeal](#)
- [The Appeals Process](#)
- [? Hours of Operation](#)


Your privacy is important.

For details about our use of your information, we encourage you to read our [Privacy Act Statement](#).

[Privacy Policy](#) | [Website Policies & Other Important Information](#) | [About Us](#) | [Site Map](#)

Last reviewed or modified January 1, 2010 12:00 PM

3.2. Screening



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Information about the Applicant

The information collected here refers to the adult or child whose disability decision is being appealed.

Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

Social Security Number (SSN):


Date of Birth:

-- ▾	<input type="text"/>	<input type="text"/>
Month	Day	Year

[Next](#) [Previous](#)

3.3. Screening: Lives in US

If state or territory is selected here, it is propagated to Applicant Detail page.

 **Social Security**
Official Website of the U.S. Social Security Administration

Disability Appeal

Information about the Applicant
The information collected here refers to the adult or child whose disability decision is being appealed.

Name:


First Middle Last Suffix

Social Security Number (SSN):

Date of Birth:

Month Day Year

3.4. Who is Entering Appeal



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you Sarah Jones or are you entering this appeal on his/her behalf?

I am Sarah Jones.

I am entering this appeal for Sarah Jones.

[Next](#) [Previous](#)

3.5. Who is Entering Appeal: Entering for Sarah Jones

Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you Sarah Jones or are you entering this appeal on his/her behalf?

I am Sarah Jones.

I am entering this appeal for Sarah Jones.

What is your relationship to Sarah Jones?

--

What is your name?

First Middle Last Suffix

[Next](#) [Previous](#)

Contents of relationship drop list:

-
- Appointed Representative (Attorney) or Staff
- Appointed Representative (Non-Attorney) or Staff
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

3.6. Who is Entering Appeal: Representative Selected



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you Sarah Jones or are you entering this appeal on his/her behalf?

I am Sarah Jones.
 I am entering this appeal for Sarah Jones.

What is your relationship to Sarah Jones?

Appointed Representative (Attorney) or Staff

Representative's Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	--
First	Middle	Last	Suffix

[Next](#) [Previous](#)

3.7. Who is Entering Appeal: Other Selected



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you Sarah Jones or are you entering this appeal on his/her behalf?

I am Sarah Jones.
 I am entering this appeal for Sarah Jones.

What is your relationship to Sarah Jones?

Other

Please specify your relationship:


What is your name?

First Middle Last Suffix

[Next](#) [Previous](#)

3.8. Reentry Number – 3rd Party

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.

 **Social Security**
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

i Please print this page or write down the reentry number.


Reentry Number: **37649726**

Website: www.socialsecurity.gov/disability/appeal

Select **Return to a Saved Appeal**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal later.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

Would you like us to email you this reentry number?
Please note, only the reentry number will be sent.

Yes No


Next Save & Exit

In this section...

- Reentry Number**
- [Preparer](#)
- [Applicant Information](#)
- [Representative](#)
- [Request for Hearing](#)

3.9. Reentry Number – 3rd Party: Email Selected

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Please print this page or write down the reentry number.


Reentry Number: **37649726**

Website: www.socialsecurity.gov/disability/appeal

Select **Return to a Saved Appeal**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal later.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

Would you like us to email you this reentry number?
Please note, only the reentry number will be sent.

Yes No

Email Address:


Confirm Email Address:

Next Save & Exit

In this section...


- Reentry Number**
- [Preparer](#)
- [Applicant Information](#)
- [Representative](#)
- [Request for Hearing](#)

3.10. Are You Sure You Want to Exit – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

 **Are you sure you want to exit?**


Before you select "Yes, I Want to Exit" below, be sure you have the following information so you will be able to continue the appeal for Sarah Jones later.

Reentry Number: **37649726**


Website: www.socialsecurity.gov/disability/appeal

Select **Return to a Saved Appeal**

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

3.11. Return to a Saved Appeal – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Return to a Saved Appeal


Please enter the Reentry Number and Social Security Number to continue where you left off. If you don't have a Reentry Number, you will need to start a new appeal.

Reentry Number:

Applicant's Social Security Number (SSN):

[Next](#) [Previous](#)

3.12. Who are You – 3rd Party

 **Social Security**
Official Website of the U.S. Social Security Administration

Disability Appeal

Please Confirm Your Identity

I am:

- Sarah Jones
- Terry Halpern
- Pat Graham
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal


[Next](#)

The possibilities for the radio list are determined based on data already provided in the claim. The names shown would correspond to the roles, which should be shown in the following order:

1. claimant (always appears)
2. third party preparer, if any
3. person listed on "Someone we can contact" page, if any
4. representative, if any, if different from preparer
5. someone else, helping <claimant name> to appeal (always appears)

If option 5 is selected and completed, the data entered replaces any preparer information previously provided.

3.13. Who are You – 3rd Party: Someone Else



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Please Confirm Your Identity

I am:

- Sarah Jones
- Terry Halpern
- Pat Graham
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal

What is your relationship to Sarah Jones?

Your Name:

First Middle Last Suffix

Your Mailing Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Your Daytime Phone Number:

U.S. International


10-digit Number [Ext.](#)

Contents of relationship drop list:

--

- Appointed Representative (Attorney) or Staff
- Appointed Representative (Non-Attorney) or Staff
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

3.14. Who are You – 3rd Party: Other Selected



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Please Confirm Your Identity

I am:

- Sarah Jones
- Terry Halpern
- Pat Graham
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal

What is your relationship to Sarah Jones?

Other

Please specify:

Your Name:

First Middle Last Suffix

Your Mailing Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Your Daytime Phone Number:

U.S. International

10-digit Number Ext.

Next

3.15. Preparer – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Information about Terry Halpern

Your Mailing Address:

Country:
United States or U.S. Territory

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Your Daytime Phone Number:
 U.S. International

10-digit Number Ext.


In this section...

- Reentry Number
- Preparer**
- Applicant Information
- Representative
- Request for Hearing

Next Previous Save & Exit

3.16. Rep Information – 3rd Party Professional Rep

Note: the right-hand secondary navigation adjusts based on selections made in the screening stages. In this example, the representative is completing the appeal.



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Information about Pat Graham

Your Mailing Address:

Country:
United States or U.S. Territory

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Daytime Phone Number:
 U.S. International

10-digit Number Ext.

FAX Number, if any:
 U.S. International

10-digit Number


[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- Reentry Number
- Representative**
- Applicant Information
- Request for Hearing

3.17. Applicant Info – 3rd Party

State is prefilled based on selection on screening page, if applicable. Gender is only asked of third parties.



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Information about Sarah Jones

Name:
Sarah Ann Jones --
First Middle Last Suffix

Gender:
We only use this information to customize how we ask the questions for this appeal.
 Male Female

Mailing Address:

Country:
United States or U.S. Territory

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** -- **ZIP Code:**

Does Sarah Jones live at the above address?
 Yes No

Daytime Phone Number:
 U.S. International

10-digit Number Ext.

Alternative Phone Number, if any:
Please provide another phone number where we can reach Sarah Jones.
 U.S. International

10-digit Number Ext.

In this section...

- Reentry Number
- Preparer
- Applicant Information**
- Representative
- Request for Hearing

Email Address for Sarah Jones:

Confirm Email Address:

Next

Previous


Save & Exit

3.18. Rep – 3rd Party

This version of the Representative page would be shown only if a representative has not already been identified.

The screenshot shows the Social Security Administration's 'Disability Appeal' interface. At the top left is the Social Security Administration logo and the text 'Social Security Official Website of the U.S. Social Security Administration'. Below this is a header for 'Disability Appeal' and a navigation bar with four tabs: 'Identification', 'Medical', 'Activities/Training', and 'Review'. The 'Medical' tab is currently selected. The main content area is titled 'Representative for Sarah Jones' and contains a question: 'Does Sarah Jones currently have an appointed representative?' with radio button options for 'Yes' and 'No'. Below the question are three buttons: 'Next', 'Previous', and 'Save & Exit'. On the right side, there is a sidebar titled 'In this section...' with a list of items: 'Reentry Number', 'Preparer', 'Applicant Information', 'Representative', and 'Request for Hearing'. The 'Representative' item is highlighted with a dark blue background.

3.19. Rep – 3rd Party: Yes Selected



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Representative for Sarah Jones

Does Sarah Jones currently have an appointed representative?
 Yes No

Representative's Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	--	▼
First	Middle	Last	Suffix	

Is the representative an attorney?
 Yes No

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** ▼ **ZIP Code:**

Daytime Phone Number:
 U.S. International

10-digit Number [Ext.](#)

FAX Number, if any:


10-digit Number

Next Previous Save & Exit

In this section...

- Reentry Number
- Preparer
- Applicant Information
- Representative**
- Request for Hearing

3.20. Request for Reconsideration – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Identification | **Medical** | Activities/Training | Review

Request for Reconsideration for Sarah Jones

What is the date on the "Notice of Decision" Sarah Jones received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

Sarah Jones disagrees with the determination made on her claim and requests reconsideration because: [What details to include](#)

Enter a brief reason for her appeal. (200 characters maximum)


Characters remaining: 200

In this section...

- ✓ Reentry Number
- ✓ Preparer
- ✓ Applicant Information
- ✓ Representative
- Request for Reconsideration**

Next | Previous | Save & Exit

3.21. Request for Hearing – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Identification | **Medical** | Activities/Training | Review

Request for Hearing for Sarah Jones

What is the date on the "Notice of Decision" Sarah Jones received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: [What details to include](#)

Enter a brief reason for her appeal. (200 characters maximum)

Characters remaining: 200

Does Sarah Jones wish to appear at a hearing? [More info about appearing](#)

Sarah Jones wishes to appear at a hearing.


Sarah Jones does not wish to appear at a hearing and requests that a decision be made based on the evidence in her case. ([Complete Waiver Form HA-4608](#))

In this section...

- ✓ Reentry Number
- ✓ Representative
- ✓ Applicant Information
- Request for Hearing**

Next | Previous | Save & Exit

3.22. Someone We Can Contact – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0000-0000
Paperwork Reduction Act

Identification Medical Activities/Training Review

Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Who can help us with this appeal?


Terry Halpern
 Someone else
 No one

Next Previous Save & Exit

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.23. Someone We Can Contact – 3rd Party: No one selected



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0000-0000
Paperwork Reduction Act

Identification Medical Activities/Training Review

Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Who can help us with this appeal?

Terry Halpern
 Someone else
 No one

i We recommend that you provide a contact, if available.

Having the name of someone who knows Sarah Jones may help us make a decision on her appeal. Doctors and hospitals may not have a complete picture of how her conditions affect her daily life and work.

You can change the selection above to provide the contact information of someone who knows Sarah Jones.

Next Previous Save & Exit

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.24. Someone We Can Contact – 3rd Party: Someone else selected

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Someone We Can Contact about Sarah Jones's Medical Conditions
Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Who can help us with this appeal?

Terry Halpern
 Someone else
 No one

Name:

First Middle Last Suffix

Relationship to Sarah Jones:

--

Does this person live with Sarah Jones?

Yes No

Does this person have the same daytime phone number as Sarah Jones?

Yes No

Can this person speak and understand English?

Yes No

Next Previous Save & Exit


In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Contents of relationship drop list:

-
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

3.25. Someone We Can Contact – 3rd Party: Follow up questions



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0000-0000
Paperwork Reduction Act

[Identification](#) | [Medical](#) | [Activities/Training](#) | [Review](#)

Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Who can help us with this appeal?

Terry Halpern
 Someone else
 No one

Name:

First Middle Last Suffix

Relationship to Sarah Jones:

Does this person live with Sarah Jones?

Yes No

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Does this person live with Sarah Jones?
 Yes No

Address:

Country:
United States or U.S. Territory ▼

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** -- ▼ **ZIP Code:**

Does this person have the same daytime phone number as Sarah Jones?
 Yes No

Daytime Phone Number:
We need to be able to contact this person during the day.
 U.S. International


10-digit Number Ext.

Can this person speak and understand English?
 Yes No

What language does the contact person prefer?
-- ▼

Next Previous Save & Exit

3.26. Someone We Can Contact – 3rd Party: Terry Halpern selected



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0000-0000
Paperwork Reduction Act

Identification Medical Activities/Training Review

Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Who can help us with this appeal?


- Terry Halpern
- Someone else
- No one

Next Previous Save & Exit

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.27. Someone We Can Contact – 3rd Party: Professional Rep



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Identification Medical **Activities/Training** Review

Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Sarah Jones doesn't have a contact.

Name:

First Middle Last Suffix

Relationship to Sarah Jones:

Does this person live with Sarah Jones?
 Yes No

Does this person have the same daytime phone number as Sarah Jones?
 Yes No

Can this person speak and understand English?
 Yes No

Next Previous Save & Exit

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.28. Section3: Medical Conditions – 3rd Party

Social Security Administration
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Change in Conditions for Sarah Jones

Since Sarah Jones last told us about her medical conditions, has there been any **CHANGE** (for better or worse) in her physical or mental conditions? [? What are changes in conditions?](#)

Yes No

New Conditions

Since Sarah Jones last told us about her medical conditions, does she have any **NEW** physical or mental conditions? [? What are new conditions?](#)

Yes No

Next Previous Save & Exit


In this section...

- Someone We Can Contact
- Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

1

¹ Note: the language for these questions has been changed per stakeholders. It does not reflect the recommendation of the User Experience Group.

3.29. Section3: Medical Conditions – 3rd Party: Follow up questions



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical Activities/Training Review

Change in Conditions for Sarah Jones

Since Sarah Jones last told us about her medical conditions, has there been any CHANGE (for better or worse) in her physical or mental conditions? [? What are changes in conditions?](#)

Yes No

Date the change(s) occurred:
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Please describe the change(s) to Sarah Jones's condition(s) in detail:
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

New Conditions

Since Sarah Jones last told us about her medical conditions, does she have any NEW physical or mental conditions? [? What are new conditions?](#)

Yes No

Date when the new condition(s) began:
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Please describe Sarah Jones's new condition(s) in detail:
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

In this section...

- Someone We Can Contact
- Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.30. Section3: Medical Conditions – 3rd Party: Remarks Pop Up


Remarks

Please provide any additional information:
Identify the question(s) these remarks apply to. You will be able to review and edit your remarks before you submit this appeal. (2000 characters maximum for your appeal)

Characters remaining: 2000

See Sarah Jones's new condition(s) in detail:
(maximum)

3.31. Section4: Medical Treatment – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Other Names for Sarah Jones

Has Sarah Jones used any other names on her medical or educational records?
For example, maiden name, other married name, or nickname.

Yes No

Medical Treatment

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled?


Yes No

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.32. Section4: Medical Treatment – 3rd Party: Follow up questions



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Other Names for Sarah Jones

Has Sarah Jones used any other names on her medical or educational records?
For example, maiden name, other married name, or nickname.

Yes No

Other Name 1:

 --

First Middle Last Suffix

Medical Treatment

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled?

Yes No

What type(s) of condition(s) was Sarah Jones treated for, or will she be seen for?

Physical Mental (including emotional or learning problems)

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

3.33. Doctors & Hospitals – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification Medical Activities/Training Review

Doctors and Hospitals for Sarah Jones

Please tell us about anyone who has **new** medical records about any of Sarah Jones's physical or mental conditions (including emotional or learning problems).

Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
Click Add Doctor to add a doctor or healthcare provider.			

Add Doctor

Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			


Add Hospital or Clinic

In this section...

- ✔ Someone We Can Contact
- ✔ Medical Conditions
- ✔ Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

Next Previous Save & Exit

3.34. Add New Doctors – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

--			--
Title	First	Last	Suffix

Name of Practice or Medical Group:

Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did Sarah Jones receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Medicines Recommended or Prescribed by this Doctor or Healthcare

Provider

Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this doctor or healthcare provider recommended or prescribed.

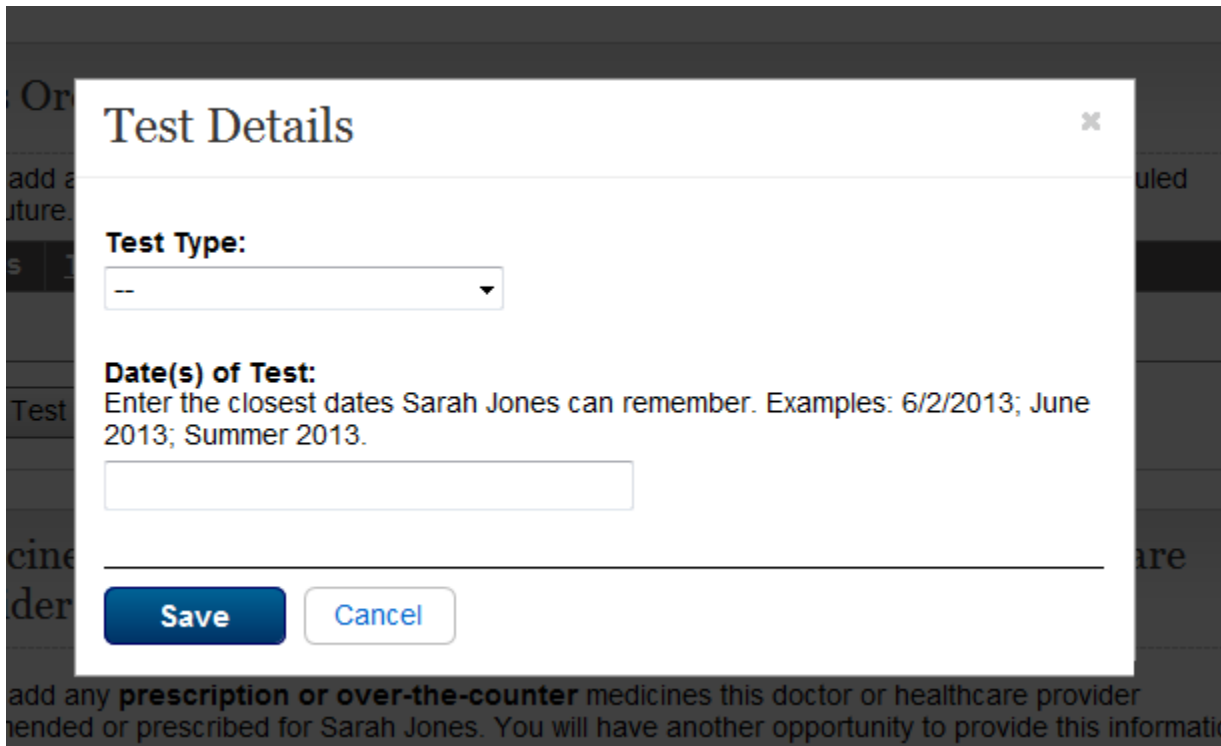
Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

3.35. Add New Doctors – 3rd Party: Test Popup



Contents of "Test Type" drop list:

-
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display a "Please specify test type" text field.

3.36. Add New Doctors – 3rd Party: Test Popup with follow up question

The image shows a 'Test Details' popup window overlaid on a dark background. The popup has a title bar with 'Test Details' and a close button (X). It contains three main sections: 'Test Type' with a dropdown menu showing 'Biopsy'; 'Body Part' with an empty text input field; and 'Date(s) of Test' with a text input field and a descriptive instruction: 'Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.' At the bottom of the popup are two buttons: 'Save' (blue) and 'Cancel' (white with blue border). The background shows a table with columns for 'Medicine', 'Reason', and 'Actions'.

3.37. Add New Doctors – 3rd Party: Medicine Popup

Medicine Details [Close]

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

What is the reason Sarah Jones is taking this medicine?

Describe any side effects Sarah Jones experienced while taking this medicine:

Characters remaining: 1000

Save **Cancel**

3.38. Doctors & Hospitals 1 Row Filled – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Doctors and Hospitals for Sarah Jones

Please tell us about anyone who has **new** medical records about any of Sarah Jones's physical or mental conditions (including emotional or learning problems).

Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
<input checked="" type="checkbox"/>	Dr. Samantha Gupta	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>


Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

3.39. Add New Hospitals – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated Sarah Jones, if known:

Phone Number:
 U.S. International

10-digit Number Ext.

Address:

Country:

Street Address:
Street Line 1:
Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did Sarah Jones have any outpatient visits at this hospital or clinic, or does she have any scheduled?
Outpatient visit means she went home the same day. This does not include emergency room visits.
 Yes No

Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?

ER visit means she went to the ER and then went home.

Yes No

Did Sarah Jones have any overnight stays at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

3.40. Add New Hospitals – 3rd Party: Yes to Treatment Dates

Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated Sarah Jones, if known:

Phone Number:
 U.S. International

10-digit Number [Ext.](#)

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did Sarah Jones have any outpatient visits at this hospital or clinic, or does she have any scheduled?
Outpatient visit means she went home the same day. This does not include emergency room visits.

Yes No

First outpatient visit:

Last outpatient visit:

Next scheduled outpatient visit (if any):

Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?

ER visit means she went to the ER and then went home.

Yes No

Please give the dates of Sarah Jones's most recent emergency room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 3:

Did Sarah Jones have any overnight stays at this hospital or clinic?

Yes No

Give us the dates of Sarah Jones's three most recent stays.

Visit 1:

Date In

Date Out

Visit 2:

Date In

Date Out

Visit 3:

Date In

Date Out

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

3.41. Doctors & Hospitals 2 Rows Filled – 3rd Party



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

✓ Identification | Medical | Activities/Training | Review

Doctors and Hospitals for Sarah Jones

Please tell us about anyone who has **new** medical records about any of Sarah Jones's physical or mental conditions (including emotional or learning problems).

Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
✓	Dr. Samantha Gupta	Baltimore	Edit Delete

Add Doctor

Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
✓	Vancouver General Hospital	Vancouver	Edit Delete

Add Hospital or Clinic


In this section...

- ✓ [Someone We Can Contact](#)
- ✓ [Medical Conditions](#)
- ✓ [Medical Treatment](#)
- Doctors and Hospitals**
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

Next | Previous | Save & Exit

3.42. Tests – 3rd Party

Table will be prefilled with what was entered in doctors/hospitals pages



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification

Medical

Activities/Training

Review

Tests for Sarah Jones

Please tell us about any medical tests Sarah Jones had or will have related to her disability.

Status	Name of Test	Test Ordered by	Actions
✔	EKG (Heart Test)	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
✔	X-Ray	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Next

Previous

Save & Exit

In this section...

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- ✔ [Doctors and Hospitals](#)
- Tests**
- [Medicines](#)
- [Other Medical Information](#)

3.43. Add New Test – 3rd Party

The screenshot shows the Social Security Administration's 'Disability Appeal' form. At the top, there is a header with the Social Security logo and the text 'Social Security Official Website of the U.S. Social Security Administration'. Below the header, the title 'Disability Appeal' is displayed. The main content area is titled 'Test Details' and contains three sections: 'Test Type:' with a dropdown menu showing '--'; 'Date(s) of Test:' with a text input field and the instruction 'Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.'; and 'Who ordered this test for Sarah Jones?' with a dropdown menu showing '--' and the instruction 'If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."'. At the bottom of the form, there are two buttons: 'Save' and 'Cancel'.

Contents of Test Type drop list:

-
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part field:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display the "Please specify test type" question.

Contents of "Who recommended..." drop list:

--

(All doctors previously entered)

(All hospitals previously entered)

Other Doctor or Healthcare Provider


Other Hospital or Clinic

No one recommended or prescribed this medicine

I don't know

3.44. Add New Test – 3rd Party: Follow up question and Other Doctor

[Text Size](#) | [Accessibility Help](#)



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:


Body Part:


Date(s) of Test:
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for Sarah Jones?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Has Sarah Jones seen this doctor or healthcare provider since she last sent us medical information? [Why we ask this](#)
 Yes No

3.45. Add New Test – 3rd Party: Have not seen the doctor

| Text Size  | Accessibility Help



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:

Body Part:

Date(s) of Test:
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for Sarah Jones?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Has Sarah Jones seen this doctor or healthcare provider since she last sent us medical information? [Why we ask this](#)
 Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who ordered this test for Sarah Jones:


<input type="text" value="--"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>
Title	First	Last	Suffix

Country:

City/Town:

State/Territory:

3.46. Add New Test – 3rd Party: Have seen the doctor



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:
--

Date(s) of Test:
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for Sarah Jones?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."
Other Doctor or Healthcare Provider

Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information? [Why we ask this](#)
 Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who ordered this test for Sarah Jones:
-- --
Title First Last Suffix

Name of Practice or Medical Group:

Doctor or Healthcare Provider's Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2: [Add More Lines](#)
City/Town: **State/Territory:** -- **ZIP Code:**

Doctor or Healthcare Provider's Phone Number:
 U.S. International

10-digit Number [Ext.](#)

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did Sarah Jones receive for the above conditions?
You DO NOT need to repeat any information that you have already told us about medicines and tests.
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)


Characters remaining: 1000

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

Please add **any prescription or over-the-counter** medicines this doctor or healthcare provider recommended or prescribed for Sarah Jones. You will have another opportunity to provide this information.

Status	Medicine	Actions
Click Add Medicine to add a medicine.		

3.47. Add New Test – 3rd Party: Other Hospital



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:
--

Date(s) of Test:
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.
[]

Who ordered this test for Sarah Jones?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."
Other Hospital or Clinic

Hospital or Clinic Details

Name of Hospital or Clinic:
[]

Name of Healthcare Provider who treated Sarah Jones, if known:
[]

Phone Number:
 U.S. International
[] []
10-digit Number Ext. []

Address:
Country:
United States or U.S. Territory

Street Address:
Street Line 1: []
Street Line 2: [] [+ Add More Lines](#)

City/Town: [] **State/Territory:** -- **ZIP Code:** []

Patient ID Number, if known:
[]

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did Sarah Jones have any outpatient visits at this hospital or clinic, or have one scheduled?
Outpatient visit means she went home the same day. This does not include emergency room visits.

Did Sarah Jones have any outpatient visits at this hospital or clinic, or have one scheduled?

Outpatient visit means she went home the same day. This does not include emergency room visits.

Yes No

Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?

ER visit means she went to the ER and then went home.

Yes No

Did Sarah Jones have any overnight stays at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Medicines Recommended or Prescribed by this Hospital or Clinic


Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save Cancel

3.48. Tests 3 Rows Filled – 3rd Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Tests for Sarah Jones

Please tell us about any medical tests Sarah Jones had or will have related to her disability.

Status	Name of Test	Test Ordered by	Actions
✓	EKG (Heart Test)	Dr. Samantha Gupta	Edit Delete
✓	Breathing Test	Dr. Samantha Gupta	Edit Delete
✓	X-Ray	Doctor(s) at Vancouver General Hospital	Edit Delete

Add Test

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- Tests**
- Medicines
- Other Medical Information

Next Previous Save & Exit

3.49. Medicines – 3rd Party

Table will be prefilled with information that was entered in doctors/hospitals pages. No medicines have been provided yet in this example.

The screenshot shows the Social Security Administration's website for a Disability Appeal. The header includes the SSA logo and the text "Social Security Official Website of the U.S. Social Security Administration". The main heading is "Disability Appeal". Below this is a navigation bar with four tabs: "Identification" (selected with a green checkmark), "Medical", "Activities/Training", and "Review".

The "Medical" section is titled "Medicines for Sarah Jones". It contains the instruction: "Please tell us about **all prescription and non-prescription medicines** that Sarah Jones is currently taking for the conditions related to her disability." Below this is a table with the following structure:

Status	Name of Medicine	Prescribed by	Actions
Click Add Medicine to add a medicine.			

Below the table is an "Add Medicine" button. At the bottom of the form are three buttons: "Next" (highlighted in blue), "Previous", and "Save & Exit".

On the right side, there is a sidebar titled "In this section...". It lists several categories, each with a green checkmark: "Someone We Can Contact", "Medical Conditions", "Medical Treatment", "Doctors and Hospitals", and "Tests". The "Medicines" category is currently selected and highlighted in white, with "Other Medical Information" listed below it.

3.50. Add New Medicine – 3rd Party

The screenshot shows the Social Security Administration's 'Disability Appeal' interface. At the top right, there are links for 'Text Size' and 'Accessibility Help'. The Social Security Administration logo and name are on the left. The main heading is 'Disability Appeal'. Below this is a 'Medicine Details' section with the following fields:


- Enter name of the medicine:** Enter only one medicine at a time. Look at the medicine container if necessary. (Text input field)
- Why is Sarah Jones taking this medicine?** (Text input field)
- Describe any side effects Sarah Jones experienced while taking this medicine:** Include physical or mental effects and allergic reactions. (1000 characters maximum) (Text area)
- Who recommended or prescribed this medicine?** If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic." (Dropdown menu)

At the bottom of the form, there are 'Save' and 'Cancel' buttons. A character count shows 'Characters remaining: 1000'.

Contents of "Who recommended..." drop list:

-
- (All doctors previously entered)*
- (All hospitals previously entered)*
- Other Doctor or Healthcare Provider
- Other Hospital or Clinic
- No one recommended or prescribed this medicine
- I don't know

3.51. Add New Medicine – 3rd Party: Other doctor



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Disability Appeal

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why is Sarah Jones taking this medicine?

Describe any side effects Sarah Jones experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)


Characters remaining: 1000

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information? [? Why we ask this](#)

Yes No

3.52. Add New Medicine – 3rd Party: Have not seen the doctor



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Disability Appeal

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why is Sarah Jones taking this medicine?

Describe any side effects Sarah Jones experienced while taking this medicine:

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Doctor or Healthcare Provider

Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information? [? Why we ask this](#)

Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who prescribed this medicine:

-- Title First Last -- Suffix

Country:

United States or U.S. Territory

City/Town:


State/Territory:

--

Save

Cancel

3.53. Add New Medicine – 3rd Party: Have seen the doctor



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Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why is Sarah Jones taking this medicine?

Describe any side effects Sarah Jones experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

▲

▼

Characters remaining: 1000

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information? [? Why we ask this](#)

Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who prescribed this medicine:

<input type="text" value="--"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>
Title	First	Last	Suffix

Name of the Practice or Medical Group:

Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did Sarah Jones receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)


Characters remaining: 1000


Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

3.54. Add New Medicine – 3rd Party: Other Hospital

| Text Size  | Accessibility Help



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Medicine Details


Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why is Sarah Jones taking this medicine?

Describe any side effects Sarah Jones experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Hospital or Clinic 

Hospital or Clinic Details

Name of Hospital or Clinic where this medicine was prescribed or recommended:

Name of Healthcare Provider who treated Sarah Jones, if known:

Phone Number:

U.S. International

U.S. International

10-digit Number Ext.

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic
 Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did Sarah Jones have any outpatient visits at this hospital or clinic, or have one scheduled?
 Outpatient visit means she went home the same day. This does not include emergency room visits.

Yes No

Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?
 ER visit means she went to the ER and then went home.

Yes No

Did Sarah Jones have any overnight stays at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?
 Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic


Please add any tests this hospital or clinic ordered for Sarah Jones, including scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Save Cancel

3.55. Medicines 3 Rows Filled – 3rd Party



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Disability Appeal

Identification Medical Activities/Training Review

Medicines for Sarah Jones

Please tell us about **all prescription and non-prescription medicines** that Sarah Jones is currently taking for the conditions related to her disability.

Status	Name of Medicine	Prescribed by	Actions
✓	Singulair	Dr. Samantha Gupta	Edit Delete
✓	Plavix	Doctors at Vancouver General Hospital	Edit Delete
✓	Cymbalta	Dr. Elijah Saunders	Edit Delete

Add Medicine

Next Previous Save & Exit

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- ✓ Tests
- Medicines**
- Other Medical Information

3.56. Section5: Other Medical Info – 3rd Party



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Disability Appeal

Identification Medical **Activities/Training** Review

Other Medical Information for Sarah Jones

We need to know if anyone else has medical information about any of Sarah Jones's conditions or if she is scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid Sarah Jones disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since Sarah Jones last told us about her other medical information, does anyone have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else?

Yes No

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

3.57. Section5: Other Medical Info – 3rd Party: Yes selected



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Disability Appeal

✔ Identification

Medical

Activities/Training

Review

Other Medical Information for Sarah Jones

We need to know if anyone else has medical information about any of Sarah Jones's conditions or if she is scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid Sarah Jones disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since Sarah Jones last told us about her other medical information, does anyone have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else?

Yes
 No

Status	Medical Information Source	City	Phone	Actions
Click Add Source to add a medical information source.				

Next

Previous

Save & Exit

In this section...

✔ [Someone We Can Contact](#)

✔ [Medical Conditions](#)

✔ [Medical Treatment](#)


✔ [Doctors and Hospitals](#)

✔ [Tests](#)

✔ [Medicines](#)

✔ [Other Medical Information](#)

3.58. Add Other Medical Info – 3rd Party



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Details of Other Medical Information

Name of Organization:

Claim or ID Number, if any:

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Name of Contact Person:

Phone Number:
 U.S. International

10-digit Number [Ext.](#)

Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor.
Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Date of First Contact:


Date of Last Contact:

Date of Next Contact, if any:

Reasons for Contacts:
(1000 characters maximum) If you need more space, please continue in [Remarks](#).

Characters remaining: 1000

3.59. Added Other Medical Info – 3rd Party



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Disability Appeal

Identification Medical **Activities/Training** Review

Other Medical Information for Sarah Jones

We need to know if anyone else has medical information about any of Sarah Jones's conditions or if she is scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid Sarah Jones disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since Sarah Jones last told us about her other medical information, does anyone have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else?

Yes No


Status	Medical Information Source	City	Actions
<input checked="" type="checkbox"/>	Workers' Insurance, Inc.	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

3.60. Section7: Activities – 3rd Party



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Disability Appeal

Identification Medical **Activities/Training** Review

Activities for Sarah Jones

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes No

Next Previous Save & Exit

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation

3.61. Section7: Activities – 3rd Party: Follow up question



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Disability Appeal

Identification Medical **Activities/Training** Review

Activities for Sarah Jones

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes No

Please describe the changes in her daily activities in detail:
(1000 characters maximum)


Characters remaining: 1000

Next Previous Save & Exit

In this section...

- Activities**
- Work and Education
- Vocational Rehabilitation

3.62. Section8: Work & Education – 3rd Party



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Disability Appeal

✔ Identification ✔ Medical Activities/Training Review

Work and Education for Sarah Jones

Since Sarah Jones last told us about her work, has she worked or has her work changed?
 Yes No


Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school?
 Yes No

Next Previous Save & Exit

In this section...

- Activities
- Work and Education**
- Vocational Rehabilitation

3.63. Section8: Work Education – 3rd Party: Follow up question



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Disability Appeal

Identification Medical **Activities/Training** Review

Work and Education for Sarah Jones

Since Sarah Jones last told us about her work, has she worked or has her work changed?
 Yes No

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school?
 Yes No

What type of training?
Examples: carpentry, cosmetology, plumbing, electronics, data entry or word processing courses.

Date(s) attended:

If you need to enter more information, continue in [Remarks](#).

In this section...

- Activities
- Work and Education**
- [Vocational Rehabilitation](#)

Next Previous Save & Exit

3.64. Section9: Voc Rehab – 3rd Party: First follow up question



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Disability Appeal

Identification Medical [Activities/Training](#) [Review](#)

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation**

Vocational Rehabilitation, Employment, or Other Support Services

We need to know about Sarah Jones's participation in:


- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18 - 21)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs?

Yes No

[Next](#) [Previous](#) [Save & Exit](#)

3.65. Section9: Voc Rehab – 3rd Party: Second follow up questions



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Disability Appeal

Identification Medical **Activities/Training** Review

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation**

Vocational Rehabilitation, Employment, or Other Support Services

We need to know about Sarah Jones's participation in:

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18 - 21)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs?

Yes No

Name of Organization or School:

Name of Counselor, Instructor, or Job Coach:

Phone Number:

U.S. International

10-digit Number

Address:

Country:
United States or U.S. Territory ▾

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** ▾ **ZIP Code:**

Date when Sarah Jones started participating in the plan or program:

If you need to enter more information, continue in [Remarks](#).

3.66. Remarks – 3rd Party



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Remarks for Sarah Jones

Please provide any additional information:
Use this space to provide any information Sarah Jones could not show in earlier sections of this form or any additional information Sarah Jones feels we should know about. (2000 characters maximum)


Characters remaining: 2000

In this section...

- Remarks
- Medical Release
- Summary

Next Previous Save & Exit

3.67. Medical Release – 3rd Party



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Disability Appeal

Identification Medical Activities/Training Review

Medical Release Form for Sarah Jones

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.


Is Sarah Jones with you now and can she read the Medical Release form?

Yes No

In this section...

- Remarks
- Medical Release**
- Summary

3.68. Medical Release – 3rd Party: Applicant is Present



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Medical Release Form for Sarah Jones

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is Sarah Jones with you now and can she read the Medical Release form?

Yes No

Please ask Sarah Jones to read the  [Medical Release Form](#) and make a selection below.

I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:

Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)

Print, sign and mail a paper copy of the Medical Release Form. I understand this may delay the processing of my disability claim.

Next Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

3.69. Medical Release – 3rd Party: Applicant is Not Present



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Medical Release Form for Sarah Jones

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is Sarah Jones with you now and can she read the Medical Release form?

Yes No

i After submitting the appeal, you will:


- Be presented with a link to the Medical Release form.
- Print the Medical Release form and have Sarah Jones sign it.
- Mail the signed paper copy.

Next Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

3.70. Medical Release – 3rd Party Professional Rep



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Medical Release Form for Sarah Jones

Do you have Sarah Jones's signed Medical Release form?

Yes No

Next Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

3.71. Medical Release – 3rd Party Professional Rep: Has signed form



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Medical Release Form for Sarah Jones

Do you have Sarah Jones's signed Medical Release form?

Yes No

After submitting the appeal, you can either:


- Mail her signed Medical Release form to Social Security; or
- Submit her signed Medical Release form to a local Social Security office.

Next Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release
- Summary

3.72. Medical Release – 3rd Party Professional Rep: Does not have signed form



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Disability Appeal

Identification Medical Activities/Training Review

Medical Release Form for Sarah Jones

Do you have Sarah Jones's signed Medical Release form?

Yes No

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is Sarah Jones with you and can she read the Medical Release form now?

Yes No

Next Previous Save & Exit

In this section...

- Remarks
- Medical Release**
- Summary

3.73. Medical Release – 3rd Party Professional Rep: Applicant is Present



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Disability Appeal

Identification Medical Activities/Training Review

Medical Release Form for Sarah Jones

Do you have Sarah Jones's signed Medical Release form?

Yes No

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is Sarah Jones with you and can she read the Medical Release form now?

Yes No

Please ask Sarah Jones to read the  [Medical Release Form](#) and make a selection below.

I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:

Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)


Print, sign and mail a paper copy of the Medical Release Form. I understand this may delay the processing of my disability claim.

Next Previous Save & Exit

In this section...

- Remarks
- Medical Release**
- Summary

3.74. Medical Release – 3rd Party Professional Rep: Applicant is Not Present



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Disability Appeal

Identification Medical Activities/Training Review

Medical Release Form for Sarah Jones

Do you have Sarah Jones's signed Medical Release form?

Yes No

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is Sarah Jones with you and can she read the Medical Release form now?

Yes No

After submitting the appeal, you will:

- Be presented with a link to the Medical Release form.
- Print the Medical Release form and have Sarah Jones sign it.
- Mail the signed paper copy.


Next Previous Save & Exit

In this section...

- Remarks
- Medical Release**
- Summary

3.75. Overall Summary – 3rd Party Public

Please note: If a Yes/No question is answered No, any conditional fields below are not displayed.



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Overall Summary for Sarah Jones

If you need to make any changes, please select the "Edit" button to return to that page.

Identification

Edit ✔ Information about Terry Halpern

Relationship: **Friend/Neighbor**
Mailing Address: [REDACTED]
Daytime Phone Number: [REDACTED]

Information about Sarah Jones

Edit ✔ Information about Sarah Jones

Name: **Sarah Ann Jones**
Mailing Address: [REDACTED]
Does Sarah Jones live at the above address? **Yes**
Daytime Phone Number: [REDACTED]
Alternative Phone Number: [REDACTED]
FAX Number: [REDACTED]
Email Address: [REDACTED]

Representative

Edit ✔ Representative

Does Sarah Jones currently have an appointed representative? **Yes**
Representative's Name: **Pat Graham**
Is the representative an attorney? **Yes**
Address: [REDACTED]
Daytime Phone Number: [REDACTED]
FAX Number, if any: [REDACTED]

Request for Hearing by Administrative Law Judge

Edit ✔ Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**
Claim Number, if different from SSN:
Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: **Her condition has become worse and she can't sit upright or stand for long periods of time.**
Does Sarah Jones have additional evidence to submit? **Yes**

In this section...

- ✔ Remarks
- ✔ Medical Release
- Summary**

Does Sarah Jones wish to appear at a hearing? **Yes**

Medical

Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

Medical Conditions

Have there been any CHANGES (for better for worse) in the physical or mental conditions that Sarah Jones HAS already reported? **Yes**

Date the change occurred: **early January 2013**

Please describe in detail: **Her condition is worse and she can't or stand for long periods of time. She gets dizzy. When she has difficulty breathing, she has to use her nebulizer.**

Are there any NEW physical or mental conditions that Sarah Jones has NOT already reported? **Yes**

Date the change occurred: **June**

Please describe in detail: **She is being treated for a heart condition. When she has difficulty breathing, she has to use her nebulizer.**

Medical Treatment

Has Sarah Jones used any other names on her medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

Doctors and Hospitals

Doctor or Healthcare Provider 1

Name of Doctor or Health Care Provider: **Dr. Samantha Gupta**

Name of Practice of Medical Group: **Gupta & Associates**

Phone Number: [Redacted]

Address: [Redacted]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Patient ID Number, if known:

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received: **Examinations**

Doctor or Healthcare Provider 2

Name: **Dr. Elijah Saunders**

Address: [Redacted]

Hospital or Clinic 1

Name of Hospital or Clinic: **Vancouver General Hospital**
Name of Healthcare Provider who treated Sarah Jones, if known:
Phone Number: [Redacted]
Address: [Redacted]
Patient ID Number, if known:
Emergency Room Visits: **Yes**
Emergency Room Visit 1 : **June 2013**
Inpatient Stays: **No**
Outpatient Visits: **No**
Medical conditions treated: **Heart attack**
Treatment Received:

Tests

Test 1

Test Type: **EKG (Heart Test)**
Date(s) of Test: **June 2013**
Who ordered this test? **Dr. Samantha Gupta**

Test 2

Test Type: **X-ray Chest**
Date(s) of Test: **June 2013**
Who ordered this test? **Doctor(s) at Vancouver General Hospital**

Test 3

Test Type: **Breathing Test**
Date(s) of Test: **June 2013**
Who ordered this test? **Dr. Samantha Gupta**

Medicines

Medicine 1

Medicine Name: **Singulair**
Reason: **Asthma**
Side Effects:
Prescribed by: **Dr. Samantha Gupta**

Medicine 2

Medicine Name: **Plavix**
Reason: **Heart Disease**
Side Effects:
Prescribed by: **Doctors at Vancouver General Hospital**

Medicine 3

Medicine Name: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

Medicine 4

Medicine Name: **Tylenol**

Reason: **Headaches**

Side Effects:

Prescribed by: **No one prescribed this medicine**

Edit **Other Medical Information**

Since Sarah Jones last told us about her other medical information, does anyone else have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [Redacted]

Name of Contact Person:

Phone Number: [Redacted]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied**

Activities/Training

Edit **Activities**

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions? **Yes**

Please describe the changes in her daily activities in detail: **She often becomes dizzy and has trouble breathing so she can no longer drive a car or go anywhere alone.**

Edit **Work and Education**

Since Sarah Jones last told us about her work, has she worked or has her work changed? **No**

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

What type? **Computer training**

Date(s) attended: **March-May 2013**

Edit **Vocational Rehabilitation, Employment, or Other Support**

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs? **No**

Name of Organization or School: **Online U**

Name of Counselor, Instructor, or Job Coach:

Phone Number: [Redacted]

Address: [Redacted]

Date when Sarah Jones started participating in the plan or program: **June 21, 2013**


Review

 **Remarks**


Remarks: **Sarah cannot work. She has trouble breathing and chest pain every day.**


 **Medical Release Form**

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**

 **You will not be able to change this information once you submit the appeal.**
When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.

3.76. Attach File: No Files Added

Text Size  | Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

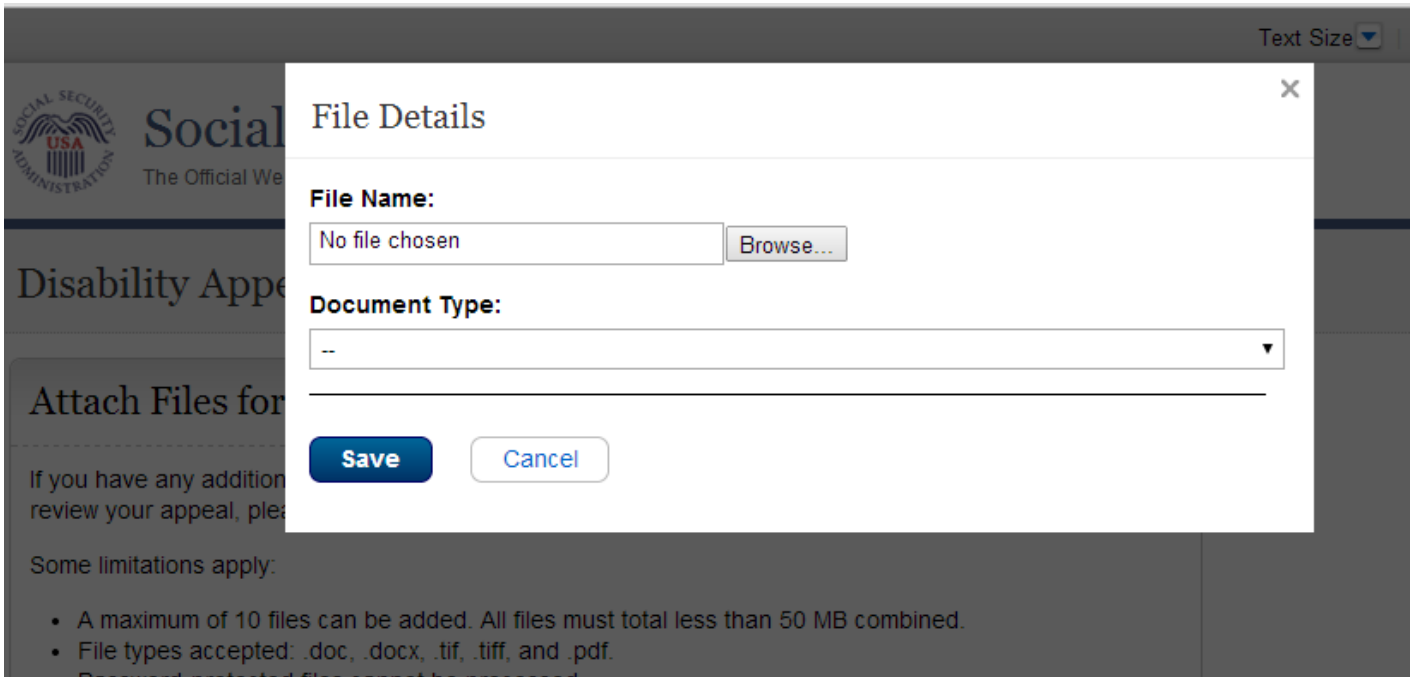
Click "Add File," then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit." If you click "Previous" or "Save & Exit," you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Click "Add File" to attach a file.			

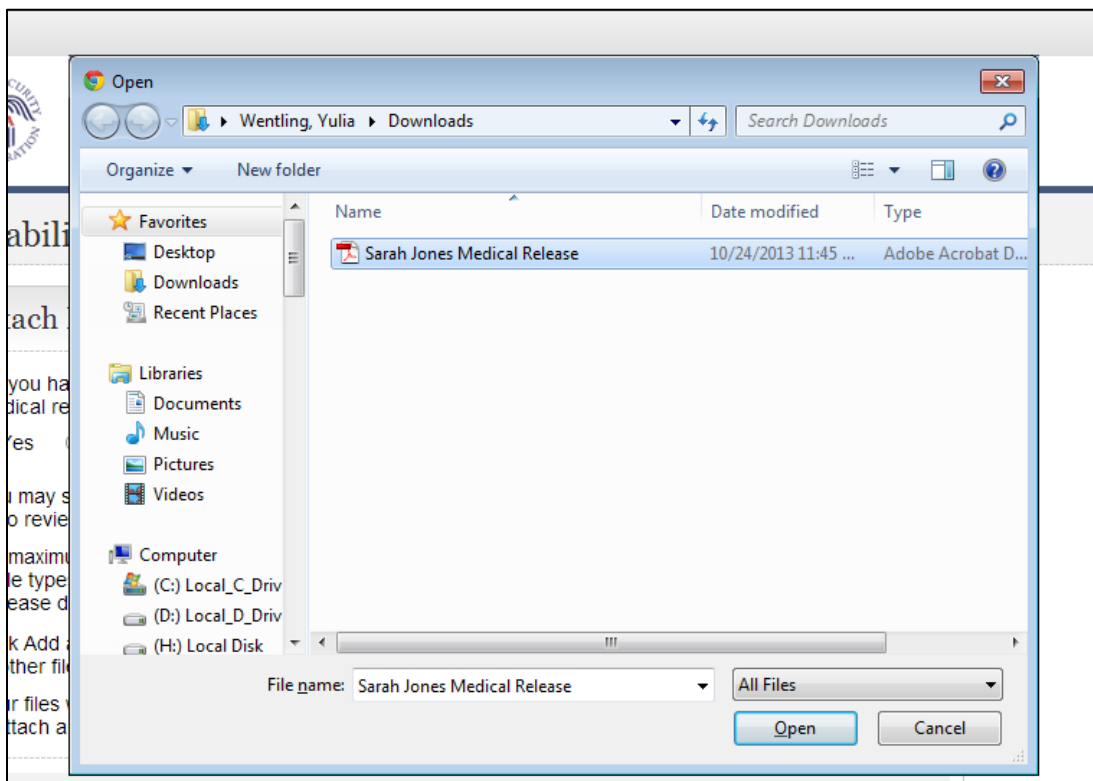
To add a file, user selects "Add File" button.

3.77. Attach Files: File Details dialog box



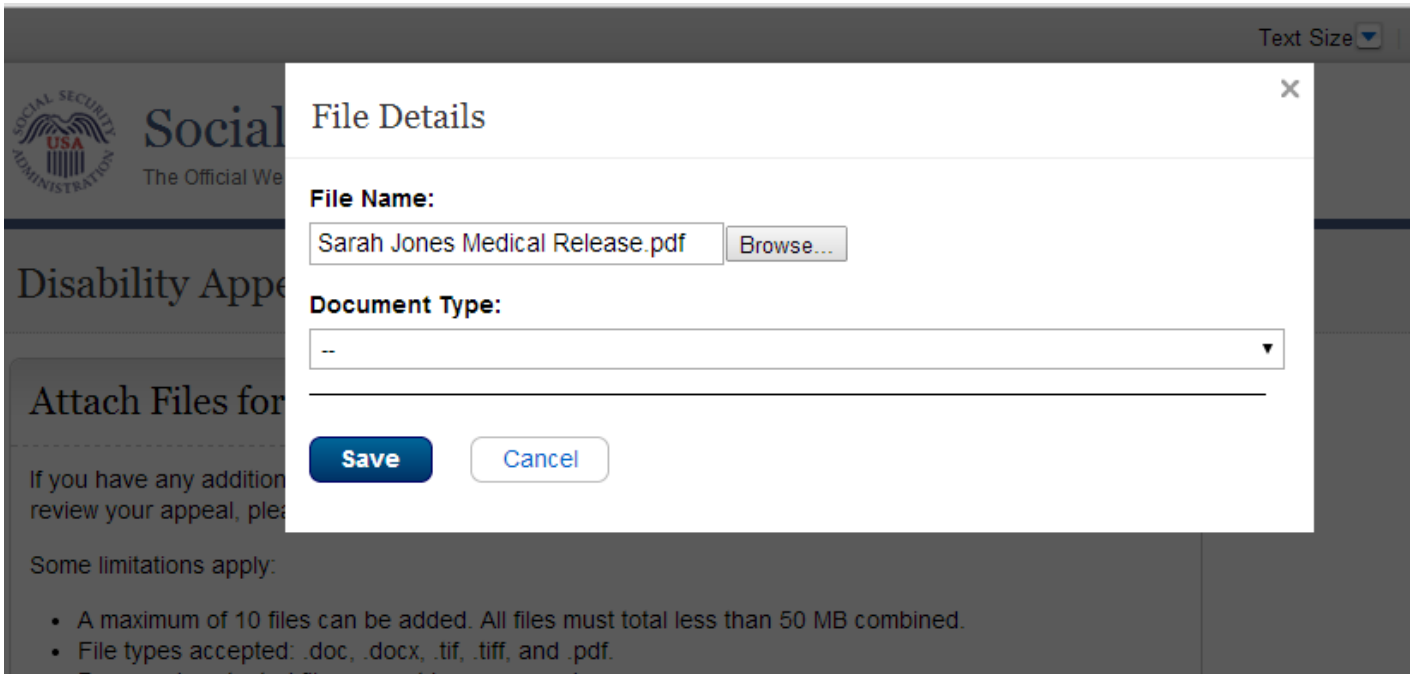
User selects “Browse” button to locate file to attach.

3.78. Attach Files: Browse for file to attach



User locates file, selects file, selects “Open”.

3.79. Attach Files: Select Document Type



User would select the type of document being attached.

List of options for Attorney Representatives & Staff and Non-Attorney Representatives & Staff:

- Appointment of Representative (SSA-1696)
- Identifying Information for Possible Direct Payment of Authorized Fees (SSA-1695)
- Fee Agreement
- Authorization to Disclose Information to the Social Security Administration (SSA-827)
- Questionnaire for Children Claiming SSI Benefits (SSA-3881)
- Good Cause for Late Filing Statement
- Representative Brief
- Waiver of Your Right to Personal Appearance Before an Administrative Law Judge (HA-4608)
- Consent for Release of Information (SSA-3288)
- Medical Evidence
- Other Evidence or Form

Note that the following options are not displayed for others:

- Identifying Information for Possible Direct Payment of Authorized Fees (SSA-1695)
- Fee Agreement
- Representative Brief

3.80. Attach Files: One file attached

Text Size | Accessibility Help

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit." If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Sarah Jones Medical Release.pdf	Medical Release (SSA-827)	186.4 KB	<input type="button" value="Delete"/>
Number of Files Attached: 1		Total Size of Attached File(s): 186.4 KB	

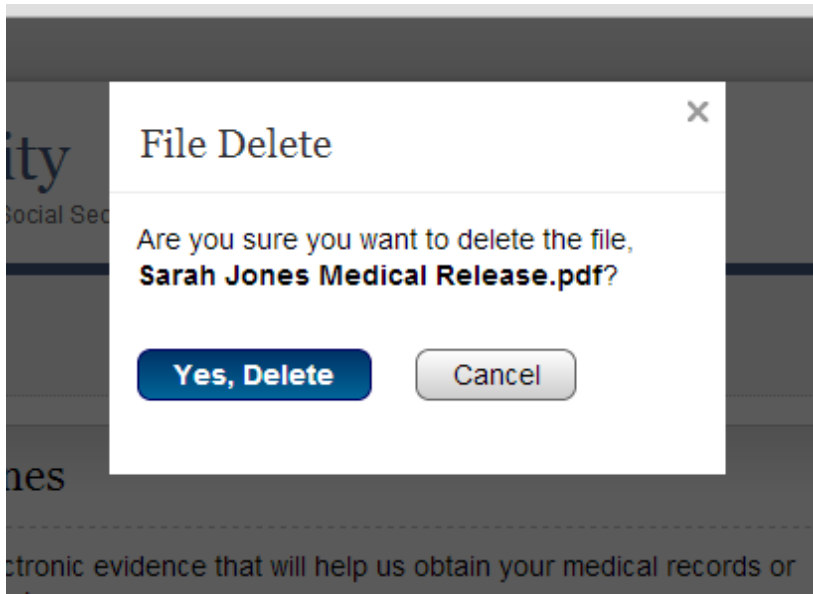
Submit

Previous

Save & Exit

3.81. Attach Files: Delete Confirmation


If user selects “Delete” button for any file, dialog box is shown to confirm.



3.82. Attach Files: Maximum (10) number of files attached

Since the user has added the maximum number of files allowed, the Add File button is no longer shown.

[Text Size](#) | [Accessibility Help](#)



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.


Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit." If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Sarah Jones Medical Release.pdf	Medical Release (SSA-827)	186.4 KB	Delete
Sarah Jones Bloodwork Results.tiff	Medical Evidence	32.2 KB	Delete
Sarah Jones Fee Agreement.pdf	Fee Agreement	186.4 KB	Delete
Sarah Jones Good Cause.doc	Good Cause for Late Filing	4.5 MB	Delete
Sarah Jones Head MRI.pdf	Medical Evidence	186.4 KB	Delete
Sarah Jones Representative Brief.tiff	Representative Brief	32.2 KB	Delete
Sarah Jones SSA 1696.pdf	Appointment of Representative (SSA-1696)	186.4 KB	Delete
Sarah Jones SSA 3288.pdf	Consent for Release of Information (SSA-3288)	186.4 KB	Delete
Sarah Jones SSA 4608.pdf	Waiver Of Your Right To Personal Appearance Before an Administrative Law Judge (HA-4608)	186.4 KB	Delete
Sarah Jones Vocational Training Record.tiff	Other Evidence or Forms	32.2 KB	Delete
Number of Files Attached: 10		Total Size of Attached File(s): 5.7 MB	


Submit
Previous
Save & Exit

3.83. Confirmation with Attachments – 3rd Party Public



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

 **You have successfully submitted Sarah Jones's Disability Appeal on August 23, 2013 at 2:30:18 PM Eastern time.**


We highly recommend that you print or save a copy of the appeal for her records.


Attachments

File Name	Document Type	Size
Sarah Jones Medical Release.pdf	Medical Release (SSA-827)	186.4 Kb
Sarah Jones Medical Evidence.pdf	Medical Evidence	201.7 Kb
Total File Size		388.1 Kb

Additional Information

You can use this [personalized cover sheet](#) if you have additional information to submit.

 [If you are unable to print](#)

 **Do you want to begin a new appeal?**

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

This sample shows an appeal with 2 files attached and uploaded.

3.84. Confirmation without Attachments – 3rd Party Public: With Bullets



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

 **You successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We highly recommend that you print or save a copy of the appeal for her records.

Additional Information


Although you have submitted Sarah Jones's disability appeal online, we still need a few items from her. Please print and have her complete the following:  [if you are unable to print](#)

- [Personalized cover sheet](#)
- [Medical Release Form \(Authorization to Disclose Information to the Social Security Administration\)](#)
-  [Instructions for completing the Medical Release Form](#)
- [Form SSA-1696 \(Appointment of Representative\)](#)

3.85. Receipt Pop up without Attachments – 3rd Party Public

Paragraph beginning "We may review..." is only displayed for a request for hearing, not a reconsideration.

Print Now **Save a Copy** [Can't print or save this document?](#)

 **You have successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We may review Sarah Jones's case to determine if we can make a decision without a hearing. If we determine she needs a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of the hearing. The hearing office assigned to Sarah Jones's case will also send her more information regarding her appeal.

Information You Submitted for Sarah Jones

Identification

Information about Terry Halpern

Home Address: [REDACTED]
Phone Number: [REDACTED]

Information about Sarah Jones

Name: **Sarah Ann Jones**
Home Address: [REDACTED]
Does Sarah Jones receive mail at her home address? **Yes**
Phone Number: [REDACTED]
Email Address: [REDACTED]

Representative

Does Sarah Jones currently have an appointed representative? **No**

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**
Claim Number:
Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the

determination made on her claim because. **Her condition has become worse and she can't sit upright or stand for long periods of time.**

Does Sarah Jones have additional evidence to submit? **Yes**

Does Sarah Jones wish to appear at a hearing? **Yes**

Medical Information

Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

Medical Conditions

Since Sarah Jones last told us about her medical conditions, has there been any change (for better or worse) in her physical or mental conditions? **Yes**

Approximate date change occurred: **January**

Please describe in detail: **Her condition is worse and she can't or stand for long periods of time. She gets dizzy. When she has difficulty breathing, she has to use her nebulizer.**

Since Sarah Jones last told us about her medical conditions, does she have any NEW physical or mental conditions? **No**

Medical Treatment

Has Sarah Jones used any other names on her medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

Doctors and Hospitals

Doctors/Hospitals Visited

Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Address: [Redacted]

Phone Number: [Redacted]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received:

Doctor or Healthcare Provider 2

Name: **Dr. Elijah Saunders**

Address: [Redacted]

Hospital or Clinic 1

Name: **Vancouver General Hospital**

Address: [Redacted]

Phone Number: [Redacted]

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **June 2013**

Inpatient Stays: **No**

Outpatient Visits: **No**

Medical conditions treated: **Heart attack**

Treatment Received:

Tests

Test 1

Kind of test: **EKG (Heart Test)**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

Test 2

Kind of test: **X-ray Chest**

Date of Test: **June 2013**

Sent for test by: **Doctor(s) at Vancouver General Hospital**

Test 3

Kind of test: **Breathing Test**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

Medicines

Medicine 1

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

Medicine 2

Medicine: **Plavix**

Reason: **Heart Disease**

Side Effects:

Prescribed by: **Doctors at Vancouver General Hospital**

Medicine 3

Medicine: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

Medicine 4

Medicine: **Tylenol**

Reason: **Headache**

Side Effects:

Prescribed by: **No one prescribed this medicine**

Other Medical Information

Since Sarah Jones last told us about her other medical information, does anyone else have medical information about any of her physical or mental conditions (including emotional and learning

information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [Redacted]

Name of Contact Person:

Phone Number: [Redacted]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

Activities/Training

Activities

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions? **Yes**

Please describe in detail the changes in her daily activities. **She often becomes dizzy and has trouble breathing so she can no longer drive a car or go anywhere alone.**

Work and Education

Since Sarah Jones last told us about her work, has she worked or has her work changed? **No**

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

Vocational Rehabilitation, Employment, or Other Support

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs? **No**

Review

Remarks


Remarks: **She will be starting to take computer training this fall.**

Medical Release Form

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Signed Electronically**

3.86. Cover Sheet Popup – 3rd Party Public

Print Now [Save a Copy](#) [Can't print or save this document?](#)



Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on Sarah Jones's claim for benefits.

Sarah Jones's Address:
[REDACTED]

Sarah Jones's Phone number:
[REDACTED]

Name and address of someone else Social Security can contact who knows about Sarah Jones's condition:
Jamie Gonzales
[REDACTED]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have

3.87. Cover Sheet Content – 3rd Party Public



Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on Sarah Jones's claim for benefits.

Sarah Jones's Address:

[Redacted]

Sarah Jones's Phone number:

[Redacted]

Name and address of someone else Social Security can contact who knows about Sarah Jones's condition:

Jamie Gonzales

[Redacted]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have
- Other (Please list below)

Name of the person completing this application:


Terry Halpern

Mail or bring to:

Social Security Administration

[Redacted]

3.88. Overall Summary – Showing section for 3rd Party Professional Rep



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical Activities/Training Review

Overall Summary for Sarah Jones

If you need to make any changes, please select the "Edit" button to return to that page.

Identification

Information about Pat Graham

Home Address: [Redacted]
Phone Number: [Redacted]

Information about Sarah Jones

Name: **Sarah Ann Jones**
Home Address: [Redacted]
Does Sarah Jones receive mail at her home address? **Yes**
Phone Number: [Redacted]
Email Address: [Redacted]

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**
Claim Number:
Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: **Her condition has become worse and she can't sit upright or stand for long periods of time.**
Does Sarah Jones have additional evidence to submit? **Yes**
Does Sarah Jones wish to appear at a hearing? **Yes**

Medical Information


Someone We Can Contact

Name: **Jamie Gonzales**
Relationship to Sarah Jones: **Family Member**
Address: [Redacted]
Daytime Phone Number: [Redacted]
Can this person speak and understand English? **Yes**

In this section...


- Remarks
- Medical Release
- Summary**

3.89. Confirmation – 3rd Party Professional Rep



Social Security
Official Website of the U.S. Social Security Administration


Disability Appeal


 **You successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We highly recommend that you print or save a copy of the appeal for her records.

Additional Information


You can use this [personalized cover sheet](#) if you have additional information to submit.

 [If you are unable to print](#)

 **Do you want to begin a new appeal?**


We can copy your contact information into the appeal. You will have the opportunity to edit it later.

3.90. Confirmation – 3rd Party Professional Rep: With Bullets




Social Security
Official Website of the U.S. Social Security Administration


Disability Appeal


 **You successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We highly recommend that you print or save a copy of the appeal for her records.

Additional Information

Although you have submitted Sarah Jones's disability appeal online, we still need a few items from her. Please print and have her complete the following:  [If you are unable to print](#)

- [Personalized cover sheet](#)
- [Medical Release Form \(Authorization to Disclose Information to the Social Security Administration\)](#)
 [Instructions for completing the Medical Release Form](#)
- [Form SSA-1696 \(Appointment of Representative\)](#)


 **Do you want to begin a new appeal?**

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

3.91. Receipt Pop up – 3rd Party Professional Rep

Paragraph beginning "an Administrative Law Judge" is only displayed for a request for hearing, not a reconsideration.

Print Now [Can't print or save this document?](#)

 **You have successfully submitted Sarah Jones's Disability Appeal on August 13, 2013 at 10:53:24 AM Eastern time.**

We may review Sarah Jones's case to determine if we can make a decision without a hearing. If we determine she needs a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of the hearing. The hearing office assigned to this case will also send Sarah Jones more information regarding her appeal.

Information for Sarah Jones

Identification

Information about Pat Graham

Home Address:

Phone Number:

Information about Sarah Jones

Name: **Sarah Ann Jones**

Home Address:

Does Sarah Jones receive mail at her home address? **Yes**

Phone Number:

Email Address:

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**

Claim Number:

Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: **Her condition has become worse and she can't sit upright or stand for long periods of time.**

Does Sarah Jones have additional evidence to submit? **Yes**

Does Sarah Jones wish to appear at a hearing? **Yes**

Medical Information

Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address: [REDACTED]

Daytime Phone Number: [REDACTED]

Can this person speak and understand English? **Yes**

Medical Conditions

Since Sarah Jones last told us about her medical conditions, has there been any change (for better or worse) in her physical or mental conditions? **Yes**

Approximate date change occurred: **January**

Please describe in detail: **Her condition is worse and she can't or stand for long periods of time. She gets dizzy. When she has difficulty breathing, she has to use her nebulizer.**

Since Sarah Jones last told us about her medical conditions, does she have any NEW physical or mental conditions? **No**

Medical Treatment

Has Sarah Jones used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

Doctors and Hospitals

Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

Doctors and Hospitals

Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Address: [REDACTED]

Phone Number: [REDACTED]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received: **Examinations**

Doctor or Healthcare Provider 2

Name: **Dr. Elijah Saunders**

Address: [Redacted]

Hospital or Clinic 1

Name: **Vancouver General Hospital**

Address: [Redacted]

Phone Number: [Redacted]

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **June 2013**

Inpatient Stays: **No**

Outpatient Visits: **No**

Medical conditions treated: **Heart attack**

Treatment Received:

Tests

Test 1

Kind of test: **EKG (Heart Test)**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

Test 2

Kind of test: **X-ray Chest**

Date of Test: **June 2013**

Sent for test by: **Doctor(s) at Vancouver General Hospital**

Test 3

Kind of test: **Breathing Test**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

Medicines

Medicine 1

Medicine: **Singularair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

Medicines

Medicine 1

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

Medicine 2

Medicine: **Plavix**

Reason: **Heart Disease**

Side Effects:

Prescribed by: **Doctors at Vancouver General Hospital**

Medicine 3

Medicine: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

Medicine 4

Medicine: **Tylenol**

Reason: **Headache**

Side Effects:

Prescribed by: **No one prescribed this medicine**

Other Medical Information

Since Sarah Jones last told us about her other medical information, does anyone else have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address:

Name of Contact Person:

Phone Number:

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

Activities/Training

Activities

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions? **Yes**

Please describe in detail the changes in her daily activities. **She often becomes dizzy and has trouble breathing so she can no longer drive a car or go anywhere alone.**

Work and Education

Since Sarah Jones last told us about her work, has she worked or has her work changed? **No**

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

Vocational Rehabilitation, Employment, or Other Support

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs? **No**

Review

Remarks

Remarks:

Medical Release Form

Have you submitted Sarah Jones's medical release form to Social Security? **Yes**

4. First Party Screen Designs


4.1. Reentry Number – 1st Party

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.

The screenshot shows the Social Security Administration's "Disability Appeal" interface. At the top left is the Social Security Administration logo and the text "Social Security Official Website of the U.S. Social Security Administration". Below this is a header for "Disability Appeal" with four tabs: "Identification", "Medical", "Activities/Training", and "Review". The "Medical" tab is selected. A light blue information box contains the following text: "Please print this page or write down the reentry number." followed by "Reentry Number: 37649726", "Website: www.socialsecurity.gov/disability/appeal", and "Select Return to a Saved Appeal". Below this, it explains that the number is used to return to a saved appeal and that losing it requires starting a new appeal. A "Print this Page" button is located below the information box. To the right of the information box is a vertical sidebar titled "In this section..." with four links: "Reentry Number", "Your Information", "Representative", and "Request for Hearing". Below the information box is a question: "Would you like us to email you this reentry number? Please note, only the reentry number will be sent." with radio buttons for "Yes" and "No". At the bottom left are two buttons: "Next" and "Save & Exit".

4.2. Reentry Number – 1st Party: Email Selected

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical Activities/Training Review

i Please print this page or write down the reentry number.


Reentry Number: **37649726**

Website: www.socialsecurity.gov/disability/appeal

Select **Return to a Saved Appeal**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal later.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

Would you like us to email you this reentry number?
Please note, only the reentry number will be sent.

Yes No

Email Address:

Confirm Email Address:

Next Save & Exit

In this section...


- Reentry Number
- Your Information
- Representative
- Request for Hearing

4.3. Are You Sure You Want to Exit

If the user did not choose to email the reentry number from the Reentry Number page, the container with the question "**Would you like us to email you this reentry number?**" - as shown on the Reentry Number page - will be displayed here above the navigation bar. If the user emailed the number previously, the page will display as shown here.

The screenshot shows the Social Security Administration's official website for a Disability Appeal. At the top left is the Social Security Administration logo. To its right is the text "Social Security" in a large blue font, with "Official Website of the U.S. Social Security Administration" in a smaller font below it. A horizontal line separates the header from the main content area. Below this line, the title "Disability Appeal" is centered. The main content area features a light blue box with a white border. Inside this box, at the top left, is an information icon (a lowercase 'i' in a circle) followed by the question "Are you sure you want to exit?". Below the question, there is a paragraph of text: "Before you select 'Yes, I Want to Exit' below, be sure you have the following information so you will be able to continue your appeal later." This is followed by three lines of text: "Reentry Number: 37649726", "Website: www.socialsecurity.gov/disability/appeal", and "Select Return to a Saved Appeal". Below this text is another paragraph: "If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy." At the bottom left of the light blue box is a "Print this Page" link with a printer icon. Below the light blue box, there are two buttons: a dark blue button with white text that says "Yes, I Want to Exit" and a light blue button with dark blue text that says "No, Return to Appeal".

4.4. Return to a Saved Appeal



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Return to a Saved Appeal

Please enter the Reentry Number and Social Security Number to continue where you left off. If you don't have a Reentry Number, you will need to start a new appeal.

Reentry Number:

Applicant's Social Security Number (SSN):

[Next](#) [Previous](#)

4.5. Who are You – 1st Party

Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Please Confirm Your Identity

I am:

- Sarah Jones
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal

Next


The possibilities for the radio list are determined based on data already provided in the claim. The names shown would correspond to the roles, which should be shown in the following order:

1. claimant (always appears)
2. person listed on "Someone we can contact" page, if any
3. representative, if any
4. someone else, helping <claimant name> to appeal (always appears)

If option 4 is selected and completed, the data entered replaces the preparer information previously provided.

Further, if any option other than claimant is selected, user will be placed into third party path (see screen 3.13. Who are You – 3rd Party: Someone Else).

4.6. Applicant Detail – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Information about You

Name:

<input type="text" value="Sarah"/>	<input type="text" value="Ann"/>	<input type="text" value="Jones"/>	--
First	Middle	Last	Suffix

Mailing Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Do you live at the above address?

Yes No

Daytime Phone Number:

U.S. International

10-digit Number Ext.

Alternative Phone Number, if any:
Please provide another phone number where we can reach you.

U.S. International

10-digit Number Ext.

Email Address:


Confirm Email Address:

Next Previous Save & Exit

In this section...

- Reentry Number
- Your Information**
- Representative
- Request for Hearing

4.7. Rep – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical Activities/Training Review

Representative

Do you currently have an appointed representative?


Yes No

Next Previous Save & Exit

In this section...

- ✓ [Reentry Number](#)
- ✓ [Your Information](#)
- Representative**
- [Request for Hearing](#)

4.8. Rep – 1st Party: Yes Selected



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification **Medical** Activities/Training Review

Representative

Do you currently have an appointed representative?
 Yes No

Representative's Name:

First: Middle: Last: Suffix:

Is the representative an attorney?
 Yes No

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Daytime Phone Number:
 U.S. International

10-digit Number Ext.

FAX Number, if any:
 U.S. International


10-digit Number

In this section...

- Reentry Number
- Your Information
- Representative**
- Request for Hearing

Next Previous Save & Exit

4.9. Request for Reconsideration – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Identification **Medical** Activities/Training Review

Request for Reconsideration

What is the date on the "Notice of Decision" you received? [? Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [? Where to find the claim number](#)

I do not agree with the determination made on the above claim and request reconsideration.
My reasons are: [? What details to include](#)
Enter a brief reason for your appeal. (200 characters maximum)


Characters remaining: 200

In this section...

- ✓ Reentry Number
- ✓ Representative
- ✓ Your Information
- Request for Reconsideration**

Next Previous Save & Exit

4.10. Request for Hearing – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Identification | **Medical** | Activities/Training | Review

Request for Hearing

What is the date on the "Notice of Decision" you received? [? Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [? Where to find the claim number](#)

I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: [? What details to include](#)
Enter a brief reason for your appeal. (200 characters maximum)

Characters remaining: 200

Do you wish to appear at a hearing? [? More info about appearing](#)

I wish to appear at a hearing.

I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. ([Complete Waiver Form HA-4608](#))

In this section...

- Reentry Number
- Your Information
- Representative
- Request for Hearing**

Next | Previous | Save & Exit

4.11. Someone We Can Contact – 1st Party

The screenshot shows the Social Security Administration's website for a Disability Appeal. The page title is "Disability Appeal" and it includes the OMB No. 0000-0000 Paperwork Reduction Act. The navigation tabs are "Identification" (selected), "Medical", "Activities/Training", and "Review".

The main section is titled "Someone We Can Contact about Your Medical Conditions" and asks the user to provide the name of someone (other than doctors) who can help with the appeal. It includes a checkbox for "I don't have a contact." and a form for entering the contact's name (First, Middle, Last, Suffix) and relationship to the user. There are also three questions with radio button options: "Does this person live with you?", "Does this person have the same daytime phone number as you?", and "Can this person speak and understand English?".


At the bottom of the form are three buttons: "Next" (highlighted in blue), "Previous", and "Save & Exit".

On the right side, there is a sidebar titled "In this section..." with a list of links: "Someone We Can Contact" (highlighted), "Medical Conditions", "Medical Treatment", "Doctors and Hospitals", "Tests", "Medicines", and "Other Medical Information".

Contents of relationship drop list:

-
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

4.12. Someone We Can Contact – 1st Party: Follow up questions



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal OMB No. 0000-0000
Paperwork Reduction Act

Identification Medical Activities/Training Review

Someone We Can Contact about Your Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about your medical conditions and can help you with this appeal.

I don't have a contact.

Name:
First: Middle: Last: Suffix:

Relationship to You:

Does this person live with you?
 Yes No

Address:
Country:

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Does this person have the same daytime phone number as you?
 Yes No

Daytime Phone Number:
We need to be able to contact this person during the day.

U.S. International
10-digit Number: Ext.:

Can this person speak and understand English?
 Yes No


What language does the contact person prefer?

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Next Previous Save & Exit

4.13. Someone We Can Contact – 1st Party: No Contact



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0000-0000
Paperwork Reduction Act

Identification Medical Activities/Training Review

Someone We Can Contact about Your Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about your medical conditions and can help you with this appeal.

I don't have a contact.

i We recommend that you provide a contact, if available.

Having the name of someone who knows you may help us make a decision on your appeal. Doctors and hospitals may not have a complete picture of how your conditions affect your daily life and your work.


You can change the selection above to provide the contact information of someone who knows you.

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Next Previous Save & Exit

4.14. Section3: Medical Conditions – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Change in Conditions

Since you last told us about your medical conditions, has there been any **CHANGE (for better or worse)** in your physical or mental conditions? [? What are changes in conditions?](#)

Yes No

New Conditions

Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions? [? What are new conditions?](#)


Yes No

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

4.15. Section3: Medical Conditions – 1st Party: Follow Up questions



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Change in Conditions

Since you last told us about your medical conditions, has there been any **CHANGE (for better or worse) in your physical or mental conditions?** [? What are changes in conditions?](#)

Yes No

Date the change(s) occurred:
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Please describe the change(s) to your condition(s) in detail:
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

New Conditions

Since you last told us about your medical conditions, do you have any **NEW physical or mental conditions?** [? What are new conditions?](#)

Yes No

Date when the new condition(s) began:
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Please describe your new condition(s) in detail:
(1000 characters maximum)


Characters remaining: 1000

If you need more space, continue in [Remarks](#).

In this section...

- Someone We Can Contact
- Medical Conditions**
 - Medical Treatment
 - Doctors and Hospitals
 - Tests
 - Medicines
 - Other Medical Information

4.16. Section4: Medical Treatment – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Other Names

Have you used any other names on your medical or educational records?
For example, maiden name, other married name, or nickname.

Yes No

Medical Treatment

Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

Yes No

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

4.17. Section4: Medical Treatment – 1st Party: Follow Up Questions



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Other Names

Have you used any other names on your medical or educational records?
For example, maiden name, other married name, or nickname.

Yes No

Other Name 1:

 --

First Middle Last Suffix

Medical Treatment

Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

Yes No

What type(s) of condition(s) were you treated for, or will you be seen for?

Physical Mental (including emotional or learning problems)

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

4.18. Doctors & Hospitals – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical **Activities/Training** Review

Doctors and Hospitals

Please tell us about anyone who has **new** medical records about any of your physical or mental conditions (including emotional or learning problems).

Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
Click Add Doctor to add a doctor or healthcare provider.			


Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

4.19. Add New Doctors – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

--			--
Title	First	Last	Suffix

Name of Practice or Medical Group:

Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Medicines Recommended or Prescribed by this Doctor or Healthcare

Provider

Please add **all prescription and non-prescription** medicines you are **currently** taking that this doctor or healthcare provider recommended or prescribed.

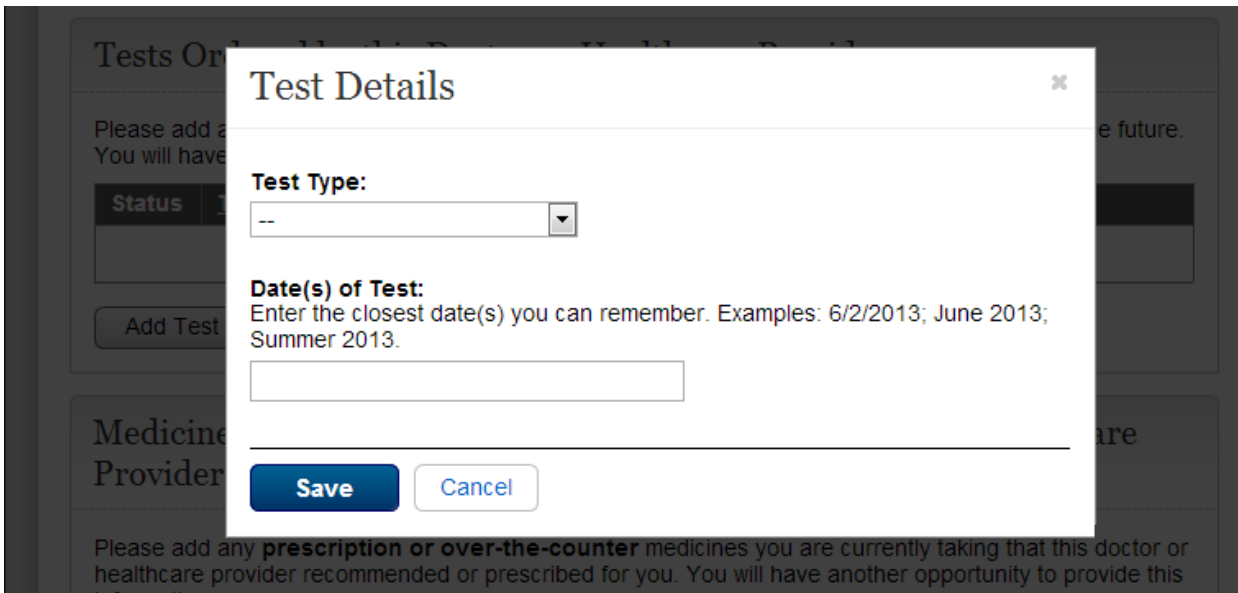
Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

4.20. Add New Doctors – 1st Party: Test Popup



Contents of "Test Type" drop list:

-
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part field:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display the "Please specify type" question.

4.21. Add New Doctors – 1st Party: Test Popup with follow up question

Test Details

Test Type:
Biopsy

Body Part:

Date(s) of Test:
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Save **Cancel**

4.22. Add New Doctors – 1st Party: Medicine Popup

Medicine Details ✕

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Save

4.23. Doctors & Hospitals – 1st Party: 1 Row Filled



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#)

Doctors and Hospitals

Please tell us about anyone who has **new** medical records about any of your physical or mental conditions (including emotional or learning problems).

Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
<input checked="" type="checkbox"/>	Dr. Samantha Gupta	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>


Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

In this section...

- [Someone We Can Contact](#)
- [Medical Conditions](#)
- [Medical Treatment](#)
- Doctors and Hospitals**
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

4.24. Add New Hospitals – 1st Party



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:
 U.S. International

10-digit Number Ext.

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes No

Did you have any emergency room (ER) visits at this hospital or clinic?

ER visit means you went to the ER and then went home.

Yes No

Did you have any overnight stays at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did you receive for the above conditions at this hospital or clinic?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.


Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

4.25. Add New Hospitals – 1st Party: Yes to Treatment Dates



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:
 U.S. International

10-digit Number [Ext.](#)

Address:

Country:

Street Address:
Street Line 1:
Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.
 Yes No

First outpatient visit:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.
 Yes No

First outpatient visit:

Last outpatient visit:

Next scheduled outpatient visit (if any):

Did you have any emergency room (ER) visits at this hospital or clinic?

ER visit means you went to the ER and then went home.

Yes No

Please give the dates of your most recent emergency room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 3:

Did you have any overnight stays at this hospital or clinic?

Yes No

Give us the dates of your three most recent stays.

Visit 1:

Date In

Date Out

Visit 2:

Date In

Date Out

Visit 3:

Date In

Date Out

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did you receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save Cancel

4.27. Doctors & Hospitals – 1st Party: 2 Rows Filled

| Text Size ▾ | Accessibility Help



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification Medical Activities/Training Review

Doctors and Hospitals

Please tell us about anyone who has **new** medical records about any of your physical or mental conditions (including emotional or learning problems).

Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
✔	Dr. Samantha Gupta	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
✔	Vancouver General Hospital	Vancouver	<input type="button" value="Edit"/> <input type="button" value="Delete"/>


In this section...

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- Doctors and Hospitals**
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

Next Previous Save & Exit

4.28. Tests – 1st Party

Table will be prefilled with what was entered in doctors/hospitals pages



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification

Medical

Activities/Training

Review

Tests

Please tell us about any medical tests you had or will have related to your disability.

Status	Name of Test	Test Ordered by	Actions
✔	EKG (Heart Test)	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
✔	X-Ray	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Next

Previous

Save & Exit

In this section...

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- ✔ [Doctors and Hospitals](#)
- Tests**
- [Medicines](#)
- [Other Medical Information](#)

4.29. Add New Test – 1st Party

The screenshot shows the Social Security Administration's 'Disability Appeal' form. The header includes the SSA logo and the text 'Social Security Official Website of the U.S. Social Security Administration'. The main heading is 'Disability Appeal'. Below this is a 'Test Details' section with three main fields: 'Test Type' (a dropdown menu currently showing '--'), 'Date(s) of Test' (a text input field with instructions: 'Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.'), and 'Who ordered this test for you?' (a dropdown menu with instructions: 'If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."'). At the bottom of the form are 'Save' and 'Cancel' buttons. In the top right corner of the browser window, there are links for 'Text Size' and 'Accessibility Help'.

Contents of "Test Type" drop list:

-
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part field:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display the "Please specify type" question.

Contents of "Who ordered..." drop list:

--

(All doctors previously entered)

(All hospitals previously entered)


Other Doctor or Healthcare Provider

Other Hospital or Clinic

No one recommended or prescribed this medicine

I don't know

4.30. Add New Test – 1st Party: Follow up question and Other Doctor



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:


Body Part:

Date(s) of Test:
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for you?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Have you seen this doctor or healthcare provider since you last gave us medical information?
[? Why we ask this](#)
 Yes No

4.31. Add New Test – 1st Party: Have not seen the doctor



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:
Biopsy

Body Part:

Date(s) of Test:
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for you?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."
Other Doctor or Healthcare Provider

Have you seen this doctor or healthcare provider since you last gave us medical information?
[Why we ask this](#)
 Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who ordered this test for you:


-- --
Title First Last Suffix

Country:
United States or U.S. Territory

City/Town:

State/Territory:
--

4.32. Add New Test – 1st Party: Have seen the doctor



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Test Details

Test Type:

Body Part:

Date(s) of Test:
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for you?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Have you seen this doctor or healthcare provider since you last gave us medical information?
[Why we ask this](#)
 Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who ordered this test for you:

<input type="text" value="--"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>
Title	First	Last	Suffix

Name of Practice or Medical Group:

Address:
Country:

Street Address:
Street Line 1:
Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Phone Number:
 U.S. International

10-digit Number [Ext.](#)

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did Sarah Jones receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

Please add **all prescription and non-prescription** medicines you are **currently** taking that this doctor or healthcare provider recommended or prescribed.


Status	Medicine	Actions
Click Add Medicine to add a medicine.		

Add Medicine

Save

Cancel

4.33. Add New Test – 1st Party: Other Hospital



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Disability Appeal

Test Details

Test Type:

Body Part:

Date(s) of Test:
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Who ordered this test for you?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Hospital or Clinic Details

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes No

Did you have any emergency room (ER) visits at this hospital or clinic?
ER visit means you went to the ER and then went home.

Yes No

Did you have any overnight stays at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did you receive for the above conditions at this hospital or clinic?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.


Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

4.34. Tests – 1st Party: 3 Rows Filled



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical Activities/Training Review

Tests

Please tell us about any medical tests you had or will have related to your disability.

Status	Name of Test	Test Ordered by	Actions
✓	EKG (Heart Test)	Dr. Samantha Gupta	Edit Delete
✓	Breathing Test	Dr. Samantha Gupta	Edit Delete
✓	X-Ray	Doctor(s) at Vancouver General Hospital	Edit Delete

Add Test

Next Previous Save & Exit

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- Tests**
- Medicines
- Other Medical Information

4.35. Medicines – 1st Party

Table will be prefilled with medicines previously entered in doctors/hospitals pages. No medicines has been provided yet in this example.

Social Security Administration
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Disability Appeal

Identification Medical Activities/Training Review

Medicines

Please tell us about **all prescription and non-prescription medicines** that you are currently taking for the conditions related to your disability.

Status	Name of Medicine	Prescribed by	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines**
- Other Medical Information

4.36. Add New Medicine – 1st Party

The screenshot shows the Social Security Administration's 'Disability Appeal' web interface. At the top right, there are links for 'Text Size' and 'Accessibility Help'. The main header features the Social Security Administration logo and the text 'Social Security Official Website of the U.S. Social Security Administration'. Below this is a section titled 'Disability Appeal'. The primary form area is titled 'Medicine Details' and contains several input fields: a text box for the medicine name, a text box for the reason for taking the medicine, and a large text area for describing side effects. A character count shows 'Characters remaining: 1000'. At the bottom of the form is a dropdown menu for 'Who recommended or prescribed this medicine?'. Below the form are two buttons: 'Save' and 'Cancel'.

Contents of "Who ordered..." drop list:

--

(All doctors previously entered)

(All hospitals previously entered)


Other Doctor or Healthcare Provider

Other Hospital or Clinic

No one recommended or prescribed this medicine

I don't know

4.37. Add New Medicine – 1st Party: Other Doctor



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Disability Appeal

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)


Characters remaining: 1000

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Have you seen this doctor or healthcare provider since you last gave us medical information?
[? Why we ask this](#)

Yes No

4.38. Add New Medicine – 1st Party: Have not seen the doctor



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Disability Appeal

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Doctor or Healthcare Provider

Have you seen this doctor or healthcare provider since you last gave us medical information?

Why we ask this

Yes No

Doctor or Healthcare Provider Details

4.39. Add New Medicine – 1st Party: Have seen the doctor

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Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Have you seen this doctor or healthcare provider since you last gave us medical information?

[? Why we ask this](#)

Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who prescribed this medicine:

Title First Last Suffix

Name of the Practice or Medical Group:

Phone Number:

U.S. International

10-digit Number Ext.

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/Territory:

--

ZIP Code:

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.


Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Save

Cancel

4.40. Add New Medicine – 1st Party: Other Hospital



Social Security
Official Website of the U.S. Social Security Administration

Disability Appeal

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:

U.S. International

10-digit Number Ext.

Address:

Country:

United States or U.S. Territory ▾

Street Address:

Street Line 1:

Street Line 2:

[+ Add More Lines](#)

City/Town:

State/Territory:

-- ▾

ZIP Code:

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?

Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes No

Did you have any emergency room (ER) visits at this hospital or clinic?

ER visit means you went to the ER and then went home.

Yes No

Did you have any overnight stays at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did you receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.


Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Save

Cancel

4.41. Medicines – 1st Party: 3 Rows Filled



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

Identification Medical Activities/Training Review

Medicines

Please tell us about **all prescription and non-prescription medicines** that you are taking for the conditions related to your disability.

Status	Name of Medicine	Prescribed by	Actions
✓	Singular	Dr. Samantha Gupta	Edit Delete
✓	Plavix	Doctors at Vancouver General Hospital	Edit Delete
✓	Cymbalta	Dr. Elijah Saunders	Edit Delete

Add Medicine

Next Previous Save & Exit

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- ✓ Tests
- Medicines**
- Other Medical Information

4.42. Section5: Other Medical Info – 1st Party



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Disability Appeal

Identification Medical **Activities/Training** Review

Other Medical Information

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

Yes No

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

4.43. Section5: Other Medical Info – 1st Party: Yes selected



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Disability Appeal

✔ Identification

Medical

Activities/Training

Review

Other Medical Information

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

Yes
 No

Status	Medical Information Source	City	Phone	Actions
Click Add Source to add a medical information source.				

Next

Previous

Save & Exit


In this section...

- ✔ Someone We Can Contact
- ✔ Medical Conditions
- ✔ Medical Treatment
- ✔ Doctors and Hospitals
- ✔ Tests
- ✔ Medicines
- Other Medical Information**

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DCS/OSes/DUAPS/USSB/UXG

4.44. Add Other Medical Info – 1st Party: Details



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Details of Other Medical Information

Name of Organization:

Claim or ID Number, if any:

Address:

Country:

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Name of Contact Person:

Phone Number:
 U.S. International

10-digit Number [Ext.](#)

Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor.
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

Date of First Contact:

Date of Last Contact:

Date of Next Contact, if any:

Reasons for Contacts:
(1000 characters maximum)

Characters remaining: 1000
If you need more space, please continue in [Remarks](#).

SaveCancel

4.45. Added Other Medical Info – 1st Party: One Row Filled



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Identification | Medical | **Activities/Training** | Review

Other Medical Information

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?


Yes No

Status	Medical Information Source	City	Actions
<input checked="" type="checkbox"/>	Workers' Insurance, Inc.	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

4.46. Section7: Activities – 1st Party



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Disability Appeal

✔ Identification ✔ Medical Activities/Training Review

Activities

Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes No

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation

Next Previous Save & Exit

4.47. Section7: Activities – 1st Party: Follow up question



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Disability Appeal

Identification Medical **Activities/Training** Review

Activities for Sarah Jones

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes No

Please describe the changes in her daily activities in detail:
(1000 characters maximum)


Characters remaining: 1000

Next Previous Save & Exit

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation

4.48. Section8: Work & Education – 1st Party



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Disability Appeal

✔ Identification ✔ Medical Activities/Training Review

Work and Education

Since you last told us about your work, have you worked or has your work changed?
 Yes No


Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?
 Yes No

Next Previous Save & Exit

In this section...

- ✔ Activities
- Work and Education**
- Vocational Rehabilitation

4.49. Section8: Work & Education – 1st Party: Follow up question



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Disability Appeal

Identification Medical [Activities/Training](#) [Review](#)

Work and Education

Since you last told us about your work, have you worked or has your work changed?
 Yes No

Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?
 Yes No

What type of training?
Examples: carpentry, cosmetology, plumbing, electronics, data entry or word processing courses.

Date(s) attended:

If you need to enter more information, continue in [Remarks](#).

Activities
Work and Education
[Vocational Rehabilitation](#)

4.50. Section9: Voc Rehab – 1st Party: First follow up question



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Disability Appeal

✔ Identification ✔ Medical Activities/Training Review

In this section...

- ✔ Activities
- ✔ Work and Education
- Vocational Rehabilitation**

Vocational Rehabilitation, Employment, or Other Support Services

We need to know about your participation in:


- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18 - 21)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs?

Yes No

Next Previous Save & Exit

4.51. Section9: Voc Rehab – 1st Party: Second follow up questions



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Disability Appeal

Identification Medical **Activities/Training** Review

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation**

Vocational Rehabilitation, Employment, or Other Support Services

We need to know about your participation in:

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18 - 21)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs?

Yes No

Name of Organization or School:

Name of Counselor, Instructor, or Job Coach:

Phone Number:
 U.S. International

10-digit Number

Address:

Country:

Street Address:
Street Line 1:
Street Line 2: [+ Add Line](#)


City/Town: **State/Territory:** **ZIP Code:**

Date when you started participating in the plan or program:

If you need to enter more information, continue in [Remarks](#).

Next Previous Save & Exit

4.52. Remarks – 1st Party



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✔ Identification ✔ Medical ✔ Activities/Training Review

Remarks

Please provide any additional information:
Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. (2000 characters maximum)


Characters remaining: 2000

In this section...

- Remarks
- Medical Release
- Summary

Next Previous Save & Exit

4.54. Medical Release – 1st Party



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Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

Medical Release Form

In order to make a decision about this disability claim, we need to obtain your:

- Medical Records
- Educational Records
- Other information related to your ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Please read the [Medical Release Form](#) and make a selection below.

I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:

Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)

Print, sign and mail a paper copy of the Medical Release Form. I understand this may delay the processing of my disability claim.


Next Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

4.55. Overall Summary – 1st Party

Please note: If a Yes/No question is answered No, any conditional fields below are not displayed.



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Disability Appeal

Identification

Medical

Activities/Training

Review

Overall Summary

If you need to make any changes, please select the "Edit" button to return to that page.

Identification

Information about You

Name: **Sarah Ann Jones**

Mailing Address:

Do you live at the above address? **Yes**

Daytime Phone Number:

Alternative Phone Number, if any:

Email Address:

Representative

Representative

Do you currently have an appointed representative? **Yes**

Representative's Name: **Pat Graham**

Is the representative an attorney? **Yes**

Address:

Daytime Phone Number:

FAX Number, if any:

Request for Hearing by Administrative Law Judge

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" you received: **06/30/2013**

Claim Number, if different from SSN:

I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: **My condition has become worse and I can't sit upright or stand for long periods of time.**

Do you wish to appear at a hearing? **Yes**

In this section...

- Remarks
- Medical Release
- Summary**

Medical

Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to You: **Family Member**

Address:

Daytime Phone Number: [REDACTED]

Can this person speak and understand English? **Yes**

Edit **Medical Conditions**

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **Yes**

Date the change(s) occurred: **early January 2013**

Please describe in detail: **My condition is worse and I can't or stand for long periods of time. I get dizzy.**

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **Yes**

Date when the new condition(s) began: **July**

Please describe your new condition(s) in detail: **I am being treated for a heart condition. When I have difficulty breathing, I have to use a nebulizer.**

Edit **Medical Treatment**

Have you used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled? **Yes**

What type(s) of condition(s) were you treated for, or will you be seen for? **Physical, Mental (including emotional or learning problems)**

Edit **Doctors and Hospitals**

Doctor or Healthcare Provider 1

Name of Doctor or Health Care Provider: **Dr. Samantha Gupta**

Name of Practice of Medical Group: **Gupta & Associates**

Phone Number: [REDACTED]

Address: [REDACTED]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Patient ID Number, if known:

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received: **Examinations**

Doctor or Healthcare Provider 2

Name: **Dr. Elijah Saunders**

Address: **Baltimore, MD**

Hospital or Clinic 1

Name of Hospital or Clinic: **Vancouver General Hospital**

Name of Healthcare Provider who treated you, if known:

Phone Number: [REDACTED]

Address: [REDACTED]

Patient ID Number, if known:

Emergency Room Visits: **Yes**
Emergency Room Visit 1 : **June 2013**
Overnight Stays: **No**
Outpatient Visits: **No**
Medical conditions treated: **Heart attack**
Treatment Received:

 **Tests**

Test 1

Test Type: **EKG (Heart Test)**
Date(s) of Test: **June 2013**
Who ordered this test? **Dr. Samantha Gupta**

Test 2

Test Type: **X-ray Chest**
Date(s) of Test: **June 2013**
Who ordered this test? **Doctor(s) at Vancouver General Hospital**

Test 3

Test Type: **Breathing Test**
Date(s) of Test: **June 2013**
Who ordered this test? **Dr. Samantha Gupta**

 **Medicines**

Medicine 1

Medicine Name: **Singularir**
Reason: **Asthma**
Side Effects:
Prescribed by: **Dr. Samantha Gupta**

Medicine 2

Medicine Name: **Plavix**
Reason: **Heart Disease**
Side Effects:
Prescribed by: **Doctors at Vancouver General Hospital**

Medicine 3

Medicine Name: **Cymbalta**
Reason: **Depression and Pain Management**
Side Effects:
Prescribed by: **Dr. Elijah Saunders**

Medicine 4

Medicine Name: **Tylenol**
Reason: **Headaches**
Side Effects:
Prescribed by: **No one prescribed this medicine**

Prescribed by: ~~No one prescribed this medicine~~

Other Medical Information

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [Redacted]

Name of Contact Person:

Phone Number: [Redacted]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reasons for Contacts: **Applied for Workers' Comp benefits and was denied**

Activities/Training

Activities

Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions? **Yes**

Please describe the changes in your daily activities in detail: **I often become dizzy and have trouble breathing.**

Work and Education

Since you last told us about your work, have you worked or has your work changed? **No**

Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

What type of training? **Computer training**

Date(s) attended: **March-May 2013**

Vocational Rehabilitation, Employment, or Other Support

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? **No**

Name of Organization or School: **Online U**

Name of Counselor, Instructor, or Job Coach:

Phone Number: [Redacted]

Address: [Redacted]

Date when you started participating in the plan or program: **June 21, 2013**


Review

Remarks

Remarks: **I cannot work. I have trouble breathing and chest pain every day.**


[Edit](#)  **Medical Release Form**


I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**

 **You will not be able to change this information once you submit the appeal.**
When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.

[Next](#) [Previous](#) [Save & Exit](#)

4.57. Attach Files: No Files Attached

Text Size  | Accessibility Help



Social Security

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Disability Appeal

Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File," then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit." If you click "Previous" or "Save & Exit," you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Click "Add File" to attach a file.			

4.58. Confirmation – 1st Party

This is a sample of a confirmation for a request for Reconsideration.




The screenshot displays the Social Security Administration's website interface. At the top left is the SSA logo, and to its right is the text "Social Security" and "Official Website of the U.S. Social Security Administration". Below this is a header section titled "Disability Appeal". The main content area features a green-bordered box with a checkmark icon and the text: "You successfully submitted your Disability Appeal on August 20, 2013 at 1:41 PM Eastern time." Below this, it says "We highly recommend that you print or save a copy of the appeal for her records." and includes a "Print or Save" button. Underneath is a section titled "Additional Information" with the text: "You can use this [personalized cover sheet](#) if you have additional information to submit." and a link: "? [If you are unable to print](#)". At the bottom left of the page is a dark blue "Done" button.

4.59. Receipt Pop up – 1st Party

In the green Confirmation notice, the paragraph beginning "an Administrative Law Judge" is only displayed for a request for hearing, not reconsideration.

Print Now **Save a Copy** [Can't print or save this document?](#)

 **You successfully submitted your Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We may review your case to determine if we can make a decision without a hearing. If we determine you need a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of the hearing. The hearing office assigned to your case will also send you more information regarding your appeal.

Information You Submitted

Identification

Information about You

Name: **Sarah Ann Jones**
Mailing Address: [REDACTED]
Do you live at the above address? **Yes**
Daytime Phone Number: [REDACTED]
Alternative Phone Number, if any: [REDACTED]
Email Address: [REDACTED]

Representative

Do you currently have an appointed representative? **No**

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" you received: **June 30, 2013**
Claim Number:
I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: **My condition has become worse and I can't sit upright or stand for long periods of time.**
Does you have additional evidence to submit? **Yes**
Do you wish to appear at a hearing? **Yes**

Does you wish to appear at a hearing? **Yes**

Medical Information

Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to You: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

Medical Conditions

Since you last told us about your medical conditions, has there been any change (for better or for worse) in your physical or mental conditions? **Yes**

Approximate date change occurred: **January**

Please describe in detail: **My condition is worse and I can't or stand for long periods of time. I got dizzy.**

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **No**

Medical Treatment

Has you used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since you last told us about her medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled? **Yes**

What type(s) of condition(s) were you treated for, or will you be seen for? **Physical, Mental (including emotional or learning problems)**

Doctors and Hospitals

Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Address: [Redacted]

Phone Number: [Redacted]

First Visit: **Sometime in 1999**
Last Visit: **June 6, 2013**
Next Scheduled Appointment: **August 1, 2013**
Medical conditions treated: **Diabetes, Heart Disease, Asthma**
Treatments Received:

Doctor or Healthcare Provider 2

Name: **Dr. Elijah Saunders**
Address: [REDACTED]

Hospital or Clinic 1

Name: **Vancouver General Hospital**
Address: [REDACTED]
Phone Number: [REDACTED]
Emergency Room Visits: **Yes**
Emergency Room Visit 1 : **June 2013**
Inpatient Stays: **No**
Outpatient Visits: **No**
Medical conditions treated: **Heart attack**
Treatment Received:

Tests

Test 1

Kind of test: **EKG (Heart Test)**
Date of Test: **June 2013**
Sent for test by: **Dr. Samantha Gupta**

Test 2

Kind of test: **X-ray Chest**
Date of Test: **June 2013**
Sent for test by: **Doctor(s) at Vancouver General Hospital**

Test 3

Kind of test: **Breathing Test**
Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

Medicines

Medicine 1

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

Medicine 2

Medicine: **Plavix**

Reason: **Heart Disease**

Side Effects:

Prescribed by: **Doctors at Vancouver General Hospital**

Medicine 3

Medicine: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

Medicine 4

Medicine: **Tylenol**

Reason: **Headache**

Side Effects:

Prescribed by: **No one prescribed this medicine**

Other Medical Information

Since you last told us about your other medical information, does anyone else have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [REDACTED]

Name of Contact Person:

Phone Number: [REDACTED]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

Activities/Training

Activities

Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions? **Yes**

Please describe in detail the changes in your daily activities. **I often becomes dizzy and have trouble breathing so I can no longer drive a car or go anywhere alone.**

Work and Education

Since you last told us about your work, have you worked or has your work changed? **No**

Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

Vocational Rehabilitation, Employment, or Other Support

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? **No**

Review

Remarks


Remarks: **I cannot work. I have trouble breathing and chest pain every day.**

Medical Release Form

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**

4.60. Cover Sheet Popup – 1st Party

Print Now [Save a Copy](#) [Can't print or save this document?](#)



Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on my claim for benefits.

My Address:
[Redacted]

My Phone number:
[Redacted]

Name and address of someone else Social Security can contact who knows about my condition:
Jamie Gonzales
[Redacted]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have

4.61. Cover Sheet Content – 1st Party



Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on my claim for benefits.

My Address:

[Redacted]

My Phone number:

[Redacted]

Name and address of someone else Social Security can contact who knows about my condition:

Jamie Gonzales

[Redacted]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have
- Other (Please list below)

Mail or bring to:

Social Security Administration

[Redacted]